

Information about this vaccination will be put on your child's health records, including records at their GP surgery and those held by the NHS.

Child's Surname (BLOCK LETTERS)	Child's Forenames	Sex M / F	Ethnicity	Date of Birth
Daytime Contact Number		Address (BLOCK LETTERS) <b>inc. postcode</b>		
School: Year Group: R <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>		Family Doctor address & telephone number		

Since <b>September 2017</b> has your child already received a flu immunisation?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Has your child ever had a nasal flu vaccination?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Is your child currently receiving treatment that severely affects their immune system? <i>(for example are they receiving treatment for leukaemia) see leaflet page 9</i>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Is anyone in your household currently or recently receiving treatment that severely affects their immune system <i>(for example chemotherapy or nursed in isolation)</i>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Does your child have a severe egg allergy? <i>(resulting in anaphylaxis)</i>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Is your child receiving salicylate therapy? <i>(ie: aspirin)</i>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Does your child have long term health conditions? <i>(if so, please give details) see leaflet page 7</i>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Has your child been diagnosed with asthma?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
<p>If <b>Yes</b>, and your child is currently taking inhaled steroids (ie: uses a preventer or regular inhaler), please enter the medication <b>name and daily dose</b> ((eg <i>Budesonide 100 micrograms, four puffs a day</i>))</p> <p>If <b>Yes</b>, and your child has taken steroid tablets because of their asthma in the past two weeks please give details:</p> <p><b>Please let the immunisation team know if your child has had to increase his or her asthma medication after you have returned this form. On the day of immunisation, please let the immunisation team know if your child has been wheezy in the past three days.</b></p>		

**PARENTAL CONSENT FOR IMMUNISATION (please complete YES or NO section)**

<p><b>YES, I DO CONSENT</b> for my child to receive the flu immunisation</p> <p><b>Signature of parent/guardian</b></p> <p>.....</p> <p>Relationship to child.....</p> <p>Date.....</p>	<p><b>NO, I DO NOT CONSENT</b> to my child receiving the flu immunisation</p> <p><b>Signature of parent/guardian</b></p> <p>.....</p> <p>Relationship to child.....</p> <p>Date.....</p>
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**For Completion by nursing staff**

Uncomplicated triage eligible for nasal flu immunisation	YES <input type="checkbox"/>	NO <input type="checkbox"/>
For nurse assessment	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Any pre session nurse action		
Triage by:	Date:	

Has the parent reported health contraindications on day of immunisation	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Child appears clinically well and eligible for Nasal Flu?	YES <input type="checkbox"/>	NO <input type="checkbox"/>

**Asthmatic children on day of immunisation**

Has the parent/child reported the child being wheezy over the past three days? YES  NO

If the child has asthma, has the parent/child reported:

- use of oral steroids in the past 14 days YES  NO
- an increase in inhaled steroids since consent form completed? YES  NO

Child eligible for Nasal Flu? YES  NO

Child does not meet PGD criteria and nurse action

Date ..... Signature ..... Designation .....

Action entered on child's electronic records YES

**FCHC staff to complete on day of immunisation only for vaccine supply under SOP**

**Child assessed and vaccine supplied by:**

Name	Designation	Signature	Child in clinical at risk group YES <input type="checkbox"/> NO <input type="checkbox"/>
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**Immunisation details**

<b>Date:</b>	<b>Batch Number:</b>	<b>Expiry Date:</b>	<b>Left nostril</b> YES / NO	<b>Right nostril</b> YES / NO
<b>Administered By:</b> <b>Name:</b>	<b>Designation:</b>	<b>Signature:</b>	Child in clinical at risk group YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>Not Given</b>	<b>Rationale</b>	<b>Action</b>	<b>Signature</b>	

\*Asthmatic children not eligible on the day of the session due to deterioration in their asthma control should be sign posted to their GP Surgery for inactivated vaccine to avoid a delay in vaccinating this 'at risk' group.