|  |  |  |  |
| --- | --- | --- | --- |
| **1** | Child’s surname | Child’s first name | Date of Birth: |
| Gender: Girl / Boy |

|  |  |  |
| --- | --- | --- |
| **2** | Would you like your child to receive the nasal flu vaccination (please tick)? NB: The vaccination contains **Gelatine** | |
| **🞏 Yes**  **(please complete sections 3 to 6 and return form to school)** | **🞏 No**  **(please return form to school)** |

|  |  |  |  |
| --- | --- | --- | --- |
| **3** | Address and Postcode | | Phone number of parent/guardian |
| Email of parent/guardian |
| GP practice | NHS number | Ethnicity |
| School name | School year group | Age of child at vaccination date |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **4** | **Has your child been diagnosed with Asthma?**  **🞏 Yes** 🞏 **No**  If **yes**, and your child is currently taking inhaled steroids (i.e. a preventer inhaler), please write the medication name and daily dose (e.g. Budesonide 100 micrograms, 4 puffs daily)  If **yes**, and your child takes steroid tablets because of their asthma, please write name and dosage:  **On the day of vaccination, please let the immunisation team know if your child has been wheezy in the past three days or if their asthma medication has increased.** | **5** | Has your child received a flu vaccine before (either by injection or nasally)? If yes, date: | Yes  🞏 | No  🞏 |
| Has your child had a confirmed **severe** egg allergy (needing hospital care)? | Yes  🞏 | No  🞏 |
| Has your child had a **severe** allergic reaction to any previous vaccines? | Yes  🞏 | No  🞏 |
| Does your child have a condition, or are they receiving treatment, that **severely** affects their immune system (e.g. leukaemia)? | Yes  🞏 | No  🞏 |
| Is anyone **living** in your household having treatment that **severely** affects their immune system (e.g. bone marrow transplant requiring isolation)? | Yes  🞏 | No  🞏 |
| Is your child taking prescribed **medication**? | Yes  🞏 | No  🞏 |
| Does your child have any long standing medical conditions? | Yes  🞏 | No  🞏 |
| If you answered yes to any of the above, please give details:    **IF YOU ARE UNSURE OF ANY ANSWERS, CHECK WITH YOUR GP BEFORE RETURNING FORM** | | |

|  |  |  |
| --- | --- | --- |
| **6** | Signature of parent/guardian (with parental responsibility) | *\*\*If your child has a long-standing medical condition and has not received the flu vaccination previously, a second dose may be necessary one month after the first.* |
| Relationship to child | Date |

|  |  |  |
| --- | --- | --- |
| **FOR OFFICE USE ONLY** | | |
| Has the parent consented (in 2) and signed (in 6)? | Yes 🞏 | No 🞏 |
| Is the child eligible for supply by HCA under PGD \_\_\_\_\_\_\_\_? | Yes 🞏 | No 🞏 |

|  |  |  |  |
| --- | --- | --- | --- |
| **Assessment completed by nurse:** | **Date** | **Signature** | **Name & Designation** |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **VACCINE GIVEN UNDER PGD \_\_\_\_\_\_\_\_\_\_** | | | | | |
|  | Date: | Time: | Batch number/Expiry date: | Administered by:- sign, print & designation: | Location: |
| 1st dose of LAIV |  |  |  |  |  |
| 2nd dose of LAIV |  |  |  |  |  |

**Nurses’ Comments:**