Office use only: Child identity confirmed by: Self ☐ School ☐

Please complete this form fully using BLOCK CAPITALS and black/blue ink. ONLY ONE CHILD PER FORM.

NHS
Coventry and Warwickshire Partnership
NHS Trust

PART 1: Patient Information and Contact Details		
Child's Surname:		Child's NHS Number:
Child's First Name:		
Child's Date of Birth:	Age:	Child's Gender: Male ☐ Female ☐
Home Address: Postcode:		Name of School: School Year: Class:
We may wish to contact you to discuss any queries and for feedback. Please provide your contact details.		
Contact Number:		
Email Address:		
GP Surgery:		

Medical Information
Please complete this section fully as any gaps may lead to the vaccine not being given. Please tick.

		Yes	No	If yes, please give details
1	Within the last 3 months has your child had a flu vaccine?	☐	☐	
2	Does your child use inhalers **daily** for asthma, and/or are they currently taking or been prescribed oral steroids in the last 14 days for respiratory disease?	☐	☐	

Drug name and strength *(Example – Clenil Modulite inhaler 100 microgram):*

_____

Dosage *(Example – 2 puffs twice a day):* _____

For steroids, when were they last prescribed: _____

3	Is your child receiving oral salicylate therapy (e.g aspirin)?	☐	☐	
4	Does your child take any other medicines not mentioned above?	☐	☐	
5	Has your child had a severe reaction to **any** previous flu vaccine or to an antibiotic called gentamicin?	☐	☐	
6	Does your child have an anaphylactic reaction (severe allergy) to eggs, which has been confirmed by a specialist doctor or at an allergy clinic?	☐	☐	
7	Has your child got a health condition that severely weakens their immune system (e.g. receiving treatment for leukaemia)?	☐	☐	
8	Is there anybody in your family that requires isolation due to being immunosuppressed	☐	☐	If yes, can your child avoid close contact with them for two weeks after receiving the nasal flu vaccine? Yes ☐ No ☐
9	Does your child suffer with any other health condition not mentioned above?	☐	☐	

PLEASE CONTINUE OVERLEAF ➡

Consent Declaration (complete only ONE part below)

I confirm that I have parental responsibility for the named child on this form.
I have read and understood the information given to me about the flu vaccine.
I understand that information provided will be shared with their GP and CHIS.

YES, I CONSENT

for my Child to receive the nasal flu vaccine.

Parent/Guardian Name: (with parental responsibility)

_____

Signature:

_____

Date: _____

Any other comments: _____

_____

_____

_____

NO, I DO NOT CONSENT

for my Child to receive the nasal flu vaccine.

Please let us know why you do not want your child to have the flu vaccine:

- ☐ Do not feel that the vaccine is necessary.
- ☐ Due to the contents of the vaccine.
- ☐ Due to a previous allergic reaction to the vaccine.
- ☐ Other (please state)

_____

Parent/Guardian Name: (with parental responsibility)

_____

Signature:

_____

Date: _____

OFFICE USE ONLY

Eligibility Assessment for Fluenz Tetra

Child eligible YES ☐ NO ☐ (See reasons below)

Assessment and/or Administration completed by:
Name, designation & signature:

Date:

Fluenz Tetra vaccine details:

Date:

Time:

Batch no. and exp. Date:

Assessment and/or Administration completed by:
Name, designation & signature:

Child not immunised today due to: *Circle one*

Absent	Exacerbation of Asthma	Vaccination at GP
Not well on the day	Rhinitis on the day	Immunosuppressant (Child)
Previous Severe Reaction	Salicylate (oral) Therapy	Immunosuppressant (Adult)
Child Refused (partially given)	Child Refused (none given)	Unsigned Form
Confirmed Anaphylaxis to egg	Unanswered medical query	