Enfield Health
Supporting Physical and Mental Health in Enfield

Office Use only: Form Check ☐

Barnet, Enfield and Haringey NHS
Mental Health NHS Trust
A University Teaching Trust

Childhood Nasal Flu Vaccination Form

Parent/Legal guardian to complete in PEN and return to school as soon as possible.

Child's Surname:	**Child's First name:**	**Known as:**
Date of Birth:	**Age:**	**NHS Number(*if known*):**
Home Address: Post code:		**GP surgery:** / **Email address:**
School:	**Year:**	**Class:**
Daytime contact telephone number of parent/guardian:		**Male/Female:**

CONSENT FOR NASAL FLU VACCINATION (Please complete even if you do NOT want your child vaccinated)

YES I consent for my child (named above) to receive the course of nasal flu vaccination
I confirm that I have parental responsibility for this child.

Parent/Guardian's name:……
Signature:……

Date:
Verbal consent given by: Confirmed by:

NO I DO NOT consent for my child (named above) to receive the course of nasal flu vaccination
I confirm that I have parental responsibility for this child.

Parent/Guardian's name:……
Signature:……

Date:
Reasons for no consent:

NB: The nasal flu vaccine contains products derived from pigs (porcine gelatine). There is no suitable alternative flu vaccine available for otherwise healthy children. More information on the flu programme is available from www.nhs.uk/child-flu-FAQ

Please tick all relevant boxes below	YES	NO	IF YES, PLEASE GIVE DETAILS
1. Has your child been diagnosed with severe asthma? **Please let the immunisation team know if your child's asthma medication increases or starts steroid tablets after you have returned this form.**	☐	☐	
2. Has your child ever been admitted to intensive care because of their asthma?	☐	☐	
3. Since September 2020 has your child received the flu vaccination?	☐	☐	
4. Is your child currently having treatment that severely affects their immune system? *(e.g. leukaemia, immune deficiencies)*	☐	☐	
5. Is anyone in your family currently having treatment that severely affects their immune system? *(e.g. need to be kept in isolation)*	☐	☐	
6. Does your child have a severe allergy to eggs that requires emergency medication or hospital treatment / admission?	☐	☐	
7. Does your child have an allergy? (state to what and symptoms) (*e.g. Gentamicin*)	☐	☐	
8. Has your child ever had a severe or bad reaction to any previous vaccinations (including flu)?	☐	☐	
9. Does your child have a medical condition? (state what and treatment)	☐	☐	
10. Is your child receiving salicylate therapy? *(i.e. aspirin)*	☐	☐	

Child not suitable for vaccination due to :

- ☐ Concerns with consent
- ☐ Medical concerns
- ☐ Child unwell
- ☐ Salicylate therapy
- ☐ Previous anaphylaxis to flu vaccine
- ☐ Heavy nasal congestion
- ☐ Severe Egg Allergy
- ☐ Immunosuppression child
- ☐ Immunosuppression other
- ☐ Received vaccination since Sept 20
- ☐ Asthma concerns
- ☐ Other:
- ☐ Child refused

Eligibility assessment on day of vaccination	YES	NO
1. **Identity of child confirmed?**	☐	☐
2. **Has the child been reported as; being wheezy over past 3 days, increased asthma medication, commenced oral steroids in last 14 days?**	☐	☐
3. **Is the child well?**	☐	☐
4. **Child suitable for fluenz vaccination under PGD? If no please state why above.**	☐	☐
Vaccine Details		

Date/Time	Batch No/Expiry date	Where given	Signature and print name	Rio Input ☐

NB: This vaccination is being prescribed and given under Patient Group Directive (PGD). Public Health England has developed the PGD template to facilitate the delivery of publicly funded immunisations in line with national recommendations

Date	Notes/Comments	Signature and Print Name

Post vaccination advice certificate given ☐ **Catch Up letter given** ☐