

Immunisation Team  
Hutton Health Suite  
John Willie Sams Centre  
Market Street  
Dudley NE23 7HS  
Tel: 01916432868 / 69

Dear Parent or Carer,

### Childhood Nasal Flu Vaccination Programme

All children in England in school years Reception to Year 7 are eligible for seasonal flu vaccination between the months of October to December.

- The **needle-free** vaccination is given as a nasal spray up each nostril.
- There is **porcine gelatin** in this vaccine
- The vaccine will protect your child and family against the flu which can be an unpleasant illness and can, rarely, cause serious complications.
- Please see the link below and then complete the attached consent form indicating your consent or non-consent.
- **Please return your completed consent form to school**
- **OR via the Freepost address**

**Freepost RUBJ-XRTJ-HSHX, Child Healthcare Immunisation Team, Northumbria Healthcare NHS Trust, The John Willie Sams Centre, Market Street, Dudley, Cramlington, NE23 7HS**

- There will only be **one opportunity** for your child to be vaccinated in school.
- We will be going into school on a pre-arranged date between October and December.
- If we need to contact you due to any health issues you have raised on the consent we will ring you prior to going into school.
- If your child misses the session in school, **your GP will not** be able to provide the vaccine unless your child is in a clinical risk group. Please contact the immunisation team to arrange a clinic appointment.
- If your child **has the vaccine at the GP, please call us** so we do not give the vaccine again.

A small number of children cannot receive the nasal flu vaccine, in particular children with severe asthma, a severely weakened immune system or a severe egg allergy, resulting in hospital admission, or those currently taking aspirin (on prescription for arthritis). It is very important that the consent form is completed with any details of these conditions.

**\*\*It is also important that you let the immunisation team know if your child has to increase his or her asthma medication after you have returned the consent form\*\***

Those children in clinical risk groups (chronic heart disease, kidney disease, liver disease, neurological disease or diabetes) who do not receive the nasal flu vaccine in school may be referred back to their own GP.

IMMUNISATION TEAM

<https://www.northumbria.nhs.uk/our-services/childrens-services/immunisations/>

**NASAL FLU IMMUNISATION CONSENT FORM**  
**THIS VACCINE CONTAINS PORCINE GELATIN**

Child's full name (first name and surname):	Date of birth: ____/____/____	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>
Home address:	Daytime telephone number for parent /carer:	
	Ethnicity:	
School:	Year group/class:	
GP name and address:	NHS number (if known):	

**PLEASE ANSWER ALL THE FOLLOWING QUESTIONS**

1. Has your child been diagnosed with asthma?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
2. Does your child have a severe egg allergy that has resulted in the need for hospital treatment?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
3. Is your child or any of your family currently having treatment that severely affects their immune system e.g. chemotherapy, malignancy, HIV? <b>If yes, please give details overleaf.</b>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
4. Is your child receiving salicylate therapy i.e. Aspirin?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
5. Do you agree to inform the immunisation team if your child receives the flu immunisation elsewhere (eg.at your GP) this year, from September 2020?	YES <input type="checkbox"/>	NO <input type="checkbox"/>

**CONSENT FOR THE NASAL FLU IMMUNISATION, PLEASE COMPLETE ONE BOX BELOW**

**CONSENT**

**Yes - I would like** my child to receive the nasal flu vaccination

Parent/Carer Name: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Signature \_\_\_\_\_

(Parent/Legal Guardian)

Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**NON CONSENT**

**No - I do not want** my child to have the nasal flu vaccination

Parent/Carer Name: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Signature \_\_\_\_\_

(Parent/Legal Guardian)

Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**Prior to the day of immunisation please let the team know if your child has been wheezy or has needed an increase in their asthma medication in the previous three days**