

INFLUENZA VACCINATION CONSENT FORM 2019 / 2020

PLEASE COMPLETE USING BLOCK CAPITALS IN BLACK INK



Sussex Community
NHS Foundation Trust

The Q&A sheet that accompanies this form tells you about the Influenza vaccination and why it is being offered. If you have any questions, please contact the Immunisation Team or visit the NHS Choices website www.nhs.uk (search for flu vaccine) or send an email to sc-tr.fluvacc@nhs.net

**Please ensure ALL boxes marked (*) below are complete;
any missing information may result in your child not being vaccinated on the day of the school session.**

Legal SURNAME:*	Legal Forename:*	Date of Birth:*			Male <input type="checkbox"/>
		DD	MM	YYYY	Female <input type="checkbox"/>
Name known as, if different:				Ethnicity:	
Contact Telephone Number(s) for Parent(s) / Guardian(s) * <i>We may use this number call or send a text regarding this vaccination</i>				Home Address:*	
				Postcode:*	
GP Surgery:*			NHS Number (if known):		
School:*			Year Group:*		Class Name:

Please tick either YES or NO for all of the following questions.	YES	NO
Does the above named child have any severe allergies to egg, gentamicin or previous flu vaccination?*		
Is the above named child immunocompromised? E.g. undergoing treatment for Leukaemia or in isolation.*		
Are any household members having treatment that severely affects their immune system requiring isolation? * E.g. chemotherapy, bone marrow transplant. If so, avoid close contact with them for 2 weeks.		
Is the above named child taking any medication? * If yes, give details of medication and doses below E.g. Inhalers, Immunosuppressants etc.		
Medication – extra information	Dose	Times

Consent for Influenza Vaccination Programme (please complete one box only)*

YES, I CONSENT
for the above named child to receive the Influenza vaccine.
By signing this form I confirm the following statements:
I confirm I have parental responsibility for the above named child.
I have read and understood the information given to me about the Influenza nasal vaccine.
I understand that this information will be held in the above named child's health record and also shared with their GP.
Full Name of Person with Parental Responsibility:
Signature of Person with Parental Responsibility:
Date:

NO, I DO NOT CONSENT
for the above named child to have the Influenza vaccine.
Please tick reason for declining below and return form to the school.
<input type="checkbox"/> My child has had the vaccine in the past four months.
<input type="checkbox"/> Do not feel that the vaccine is necessary.
<input type="checkbox"/> Due to a previous allergic reaction to the vaccine.
<input type="checkbox"/> Due to the contents of the vaccine.
<input type="checkbox"/> Other (please state) use separate sheet if necessary
.....
Full Name of Person with Parental Responsibility:
Signature of Person with Parental Responsibility:
Date:

Office Use – Initial appropriate box(es)

No action.....

Demographic query.....

Clinical query.....

Query Completed.....

Thank you for completing this form. Please detach and return to the school within 7 days of receipt.

Review date March 2020

