

Please return form in envelope provided to school by ..... 2019

# PRIMARY SCHOOL – Seasonal Flu Vaccination Consent Form

PLEASE COMPLETE USING A BALLPOINT PEN

Child's Surname:	Child's First name:	Date of Birth:	Male / Female
Home address:		Daytime telephone contacts (mobile & landline):	
Post code:			
GP Name and Practice:		Parent email:	
School:	Reception <input type="checkbox"/> Year 1 <input type="checkbox"/> Year 2 <input type="checkbox"/> Year 3 <input type="checkbox"/> Year 4 <input type="checkbox"/> Year 5 <input type="checkbox"/> Year 6 <input type="checkbox"/>		
Allergies:	Medical Conditions:	Regular Medication and Inhalers:	
<i>Please continue overleaf if needed</i>			

Has your child been diagnosed with asthma?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Has your child ever been admitted to intensive care because of their asthma?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<p><b>Please ensure you notify the School Nurse Team and school office – before the day of vaccination if your child:</b></p> <ul style="list-style-type: none"> <li>Has had steroid tablets or needed to increase the use of asthma medication in the 2 weeks prior to the vaccination session.</li> <li>Has been wheezy in the 3 days before the date of the vaccination session in school.</li> </ul> <p><b>As the School Nurse Team will be unable to vaccinate your child with the nasal vaccine in school.</b></p>		
Has your child already had a flu vaccination since September 2019?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does your child have a disease or treatment that severely affects their immune system?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is anyone in your close family having treatment that severely affects their immune system? (eg they need to be kept in isolation).	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does your child have a severe egg allergy? (requiring intensive care unit admission)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is your child receiving salicylate therapy? (ie Aspirin)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If you answered yes to any of the above, please give details:		
<i>Please continue overleaf if required</i>		

<p><b>Consent by parent/guardian with parental responsibility</b> I have read the product information leaflet and consent for my child to receive the flu vaccination</p> <p>Name (print) _____</p> <p>Parent/Guardian</p> <p>Signature _____ Date _____</p>		<p><b>Consent by parent/guardian with parental responsibility</b> I do not consent for my child to receive the flu vaccination</p> <p>Name (print) _____</p> <p>Parent/Guardian</p> <p>Signature _____ Date _____</p>	
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<b>FOR OFFICE USE ONLY</b>						
Pre session eligibility assessment for live attenuated influenza vaccine LAIV Form triaged - Is child eligible for LAIV?	Yes	No (reason)			Assessor (print and sign)	Date:
Eligibility assessment on day of vaccination Has the parent/child reported wheeziness in last 3 days/or use of oral steroids/or increased use of inhaled steroids in the past 2 weeks?	Yes	No	Is child eligible for LAIV?	Yes	No	If No, give details
Date	Time	Name of vaccine	Batch No / Expiry date	Immuniser (print and sign)	Place of administration	
...../...../.....						

The information you will provide on the consent form is required for the School Nursing Service for the purposes of administering immunisations in schools. This information will be processed in line with the Data Protection (Bailiwick of Guernsey) Law, 2017. For full details of our Fair Processing Notice and how we look after your data please visit: [www.gov.gg/hscprivacy](http://www.gov.gg/hscprivacy) If you don't have access to the internet please contact us and a paper copy will be provided.