Children & Young People's Health Services NORFOLK

NHS

School Immunisation Team
Childhood 'Flu Vaccination

Dear Parents/Guardians

The school-based nasal 'flu vaccination programme helps protect your child against flu. Flu can be a dangerous illness and sometimes causes serious complications. It is important to vaccinate your child every year to help protect more vulnerable friends and family by preventing the spread of flu. Your child is entitled to the vaccination free, on the NHS.

PLEASE NOTE:

- If your child has **severe asthma** and/or takes high dose inhaled steroids or steroid tablets, (or requires the injectable vaccine) please arrange to have the vaccination at your GPs.
- After you have returned the form, please let the team know if your child has taken **steroid** tablets because of their asthma in the two weeks prior to vaccination, or if your child has to increase their asthma medication. If your child has **asthma** and is **wheezy** on the day of vaccination, please inform the school.
- The vaccination contains **gelatine**. There is no suitable alternative vaccine for heathy children.
- If your child is absent on the day of vaccinations, a second attempt will be made to offer the vaccination to your child.
- Your consent will be valid for the duration of the flu vaccination programme. If your child receives the vaccine elsewhere, or you withdraw your consent, please contact the immunisation team, below.

If you would like your child to receive the vaccination, please complete sections 1 to 6 of the consent form in black ink, including the important medical information section, as any gaps may mean that we cannot give the vaccine. If you do not want your child to receive the nasal flu vaccination, please complete sections 1 and 2 only and return to school. Please note, that by your giving consent, you are agreeing to your child's electronic health record being updated by CCS NHS Trust, and your GP being notified. If the form is not returned, your child will not be vaccinated.

PLEASE ENSURE THAT THE FORM IS RETURNED TO SCHOOL AS SOON AS POSSIBLE AND THAT IT IS SIGNED BY SOMEONE WITH LEGAL* PARENTAL RESPONSIBILITY

If you require further advice or information, please contact the Norfolk School Immunisation Team: 01603 779390 or email the Immunisation Team at: norfolk.immunisationteam@nhs.net. Further information can be found in the enclosed leaflet, or online by searching 'childhood vaccinations' at: www.nhs.uk. The medical information can be accessed by typing 'Fluenz Tetra' into the search bar on this link: https://www.medicines.org.uk/emc/ A child-friendly film can be viewed at: http://www.nhs.uk/video/pages/flu-heroes-nasal-flu-spray-for-kids.aspx

Yours faithfully

Nicky Srahan
School Age Immunisation Service Lead

*LEGAL parental responsibility – a birth parent or anyone other than a birth parent who has been to court to obtain a parental responsibility agreement.

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SCHOOL IMMUNISATION TEAM 'FLU CONSENT

NHS

1	Child's surname	Child's first name	**Date of Birth:**
			Gender: Girl / Boy

2 Would you like your child to receive the nasal flu vaccination (please tick)?

☐ **Yes** (please complete sections 3 to 6 and return form to school)	☐ **No** (please return form to school)

3	Address and Postcode		Phone number of parent/guardian
			Email of parent/guardian
	GP practice	NHS number	Ethnicity
	School name	School year group	Age of child at vaccination date

4 **Has your child been diagnosed with Asthma?**

☐ **Yes** ☐ **No**

If **yes**, and your child is currently taking inhaled steroids (i.e. a preventer inhaler), please write the medication name and daily dose (e.g. Budesonide 100 micrograms, 4 puffs daily)

If **yes**, and your child takes steroid tablets because of their asthma, please write name and dosage:

On the day of vaccination, please let the immunisation team know if your child has been wheezy in the past three days or if their asthma medication has increased.

5

	Yes	No
Has your child received a flu vaccine before (either by injection or nasally)? If yes, date:	☐	☐
Has your child had a confirmed **severe** egg allergy (needing hospital care)?	☐	☐
Has your child had a **severe** allergic reaction to any previous vaccines?	☐	☐
Does your child have a condition, or are they receiving treatment, that **severely** affects their immune system (e.g. leukaemia)?	☐	☐
Is anyone **living** in your household having treatment that **severely** affects their immune system (e.g. bone marrow transplant requiring isolation)?	☐	☐
Is your child taking prescribed **medication**?	☐	☐
Does your child have any long standing medical conditions?	☐	☐

If you answered yes to any of the above, please give details:

IF YOU ARE UNSURE OF ANY ANSWERS, CHECK WITH YOUR GP BEFORE RETURNING FORM

6	Signature of parent/guardian (with parental responsibility)	***If your child has a long-standing medical condition and has not received the flu vaccination previously, a second dose may be necessary one month after the first.*
	Relationship to child	Date

FOR OFFICE USE ONLY

Has the parent consented (in 2) and signed (in 6)?	Yes ☐	No ☐
Is the child eligible for supply by HCA under PGD _____?	Yes ☐	No ☐

Assessment completed by nurse:	**Date**	**Signature**	**Name & Designation**

VACCINE GIVEN UNDER PGD _____

	Date:	Time:	Batch number/Expiry date:	Administered by:- sign, print & designation:	Location:
1st dose of LAIV					
2nd dose of LAIV					

Nurses' Comments: