

THE FLU VACCINE



This booklet will tell you what
will happen when you have the
vaccine

You will be given your form which looks like this.

Child's full legal name (first name and surname) and preferred name if different:		Date of Birth:
		Male <input type="checkbox"/> Female <input type="checkbox"/>
Home address:		Daytime contact telephone number / mobile for Parent(s) / Guardian(s)
Postcode:	NHS Number (if known):	Ethnicity:
School:		Year group:
GP name and address:		Class name:

<i>If any of the answers below are a yes please document over page Please tick relevant column</i>	YES	NO
Does your child have any <u>severe</u> allergies to egg, gentamicin or previous flu vaccination?		
Is your child immunocompromised? <i>e.g. undergoing treatment for Leukaemia or in isolation</i> <i>If so, see your GP for inactivated Influenza Vaccination</i>		
Are any household members having treatment that severely affects their immune system requiring isolation? <i>i.e. chemotherapy, bone marrow transplant. If so, avoid close contact with them for 2 weeks</i>		
Is your child taking any medication? (i.e. aspirin, inhalers, etc.) <u>Please give details of medication and doses overleaf (with their name and date of birth)</u>		
Has your child previously been identified by GP as requiring the flu vaccine due to a medical condition?		

Consent for Flu vaccination programme (Please complete one box only)

YES, I CONSENT for my child to receive the flu vaccine.
<i>By signing this form I confirm the following statements:</i> I confirm I have parental responsibility for the above named child I have read and understood the information given to me about the nasal 'flu vaccine. I understand that the information provided will be shared with my GP to update my child's health records
Full Name of Person with Parental Responsibility:
Signature of Person with Parental Responsibility:
Date:

NO, I DO NOT CONSENT for my child to have the flu vaccine.
<i>Please tick reason for declining below and return form to the school.</i> <input type="checkbox"/> My child has had (in the past four months) or will be having the vaccine at our GP surgery. <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 – Details checked and initialled by team member:

No action required

Follow up by Nurse required

When you are called by one of the nurses they will ask you some questions which might be



Your Name ?



Your Birthday ?



Where you live ?

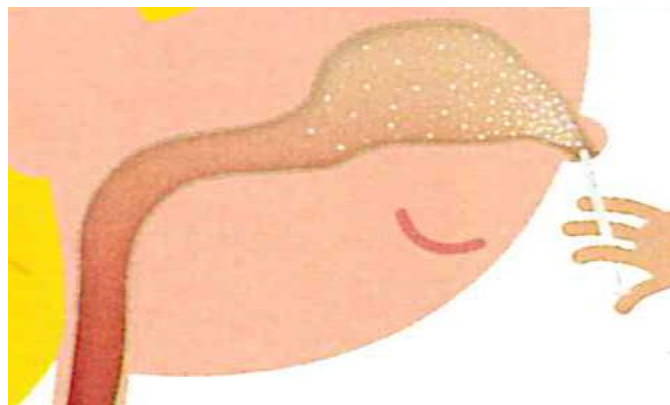


If you are feeling well ?

This is what having the flu spray looks like



The spray goes just inside your nostril



We will give you a tissue as
sometimes it makes your nose drip



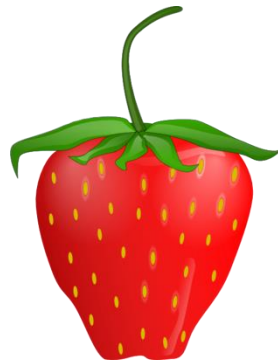
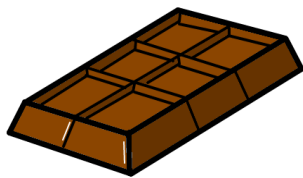
It is sprayed up BOTH sides of your
nose and feels like a tickle

IT DOES NOT HURT



As some of the flu spray's have a
smell, we will ask you what yours
smelt like

This is your very important job
We have been told that it smells of
lots of things but mostly



Or if you are really lucky



STINKY FEET !!!

As you have been brave you will also
get a certificate to take home which
looks like this



Well done!



Sussex Community **NHS**
NHS Trust

Immunisation Certificate

Name.....

has been protected against Flu!

DATE:

BATCH NO:

“Share hugs, not bugs!”



Important information for parents /
carers on the back

