Please return this tear off slip to

Long Term Conditions Team, Beech Tree Surgery, 68 Doncaster Road, Selby, YO8 9AJ

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| **Childs details** |
| Surname:  | First name: |
| Date of birth:  | Gender:  |
| NHS number (if known):  |  |
| Home address:  | Home Tel No: |
| Parents mobile number: |
| Name of person bringing your child for flu immunisation:Relationship to the child |
|  | **Please tick relevant box** |
|  | YES | NO |
| Does your child have a severe egg allergy (needing intensive care)? |  |  |
| Does your child have any allergies to gelatine/gentamycin? |  |  |
| Does your child have severe asthma which has required intensive care or who has regular oral steroids or been prescribed oral steroids in the last 14 days? |  |  |
| Is your child receiving salicylate therapy? (i.e., aspirin) |  |  |
| Does your child have a disease or treatment that severely affects their immune system? |  |  |
| Is anyone in your family currently having treatment that severely affects their immune system? (e.g., they need to be kept in isolation) |  |  |
| Conditions when Nasal flu vaccination should be postponed- please rearrange the date when your child is well. Please contact the surgery for advice if you are unsure  |
| Has your child been diagnosed with asthma and had active wheezing in the 72 hours prior to vaccination date? |  |  |
| Has your child received influenza antivirals in the 48 hours prior to vaccination date? |  |  |
| Has your child had a raised temperature and been unwell or had heavy nasal congestion (runny nose) in the 48hours prior to the vaccination date |  |  |
| Consent for immunisation (please tick) |
|  **YES,** I consent for my child to receive the flu immunisation, I can confirm I have parental  responsibility  |
| Print name: | Signature of parent/guardian: |
| Date: |