Annual Nasal flu vaccine to protect against winter flu
Consent form for school children in
Reception Classes and Years 1 to 11 inclusive

Government of JERSEY

Please complete and return this form to school before the date nurses will be in your child's school to vaccinate (this will save your child's school having to contact you). Complete a separate form for each child.

Pupil's name:	**Pupil's DOB (dd/mm/yyy):**
School name:	**Form/Year group:**
GP Practice Name:	
Parent/Guardian's daytime telephone number(s):	

Please read accompanying leaflet and answer all questions below (tick as appropriate)

1. Has your child had severe anaphylaxis to egg which required admission to intensive care? *Or* Had an anaphylaxis to flu vaccine, or any of the components in the past (other than egg)? *If yes, please give details in box below**	**Yes** ☐ **Yes** ☐	**No** ☑ **No** ☑
2. Is your child receiving salicylate therapy i.e. aspirin?	**Yes** ☐	**No** ☑
3. Does your child have a disease or treatment that severely affects their immune system? e.g. treatment for leukaemia*****	**Yes** ☐	**No** ☑
4. Is there anyone in your family currently receiving treatment that severely affects their immune system? e.g. they have to be kept in isolation*****	**Yes** ☐	**No** ☑
5. Has your child been diagnosed with asthma? *If yes and your child has taken steroid tablets because of their asthma in the past two weeks please give details** Has your child ever been admitted to intensive care because of their asthma? ***Please telephone the immunisation nurse (07797827391 / 01534 445790) if your child has to increase his or her asthma medication, or has increased wheezing, after you have returned this form to school***	**Yes** ☐ **Yes** ☐	**No** ☑ **No** ☑
***If you have answered yes to any of the above questions, please provide brief details:**		

Consent to have nasal flu vaccine at school **YES - I want my child** to have the nasal flu vaccine at school		**FOR OFFICIAL USE ONLY:**	
Parent / Guardian's Name (with parental responsibility):		Batch number:	
		Expiry date:	
		Date given (dd/mm/yyy):	
Relationship to child (please select):	Mother	Vaccine administered by (print name):	
Signature: (please type name)		Venue name (if different from school name above):	
Date (dd/mm/yyyy):			

NO - I **do not want my child** to have the nasal flu vaccine at school			
Parent / Guardian's Name (with parental responsibility):	Relationship to child: Mother	Signature: (please type name)	Date (dd/mm/yyyy):

Information that we (Health and Community Services) hold on the Child Health Information System for the purposes of providing healthcare is confidential, is used by authorised healthcare professionals and is held in accordance with the Data Protection (Jersey) Law 2005. We securely share demographic information of pre-school age children with the Education Department for their planning of educational provision and anonymised data is used by the States of Jersey Statistics Unit for statistical reporting purposes. Consent form Version 21/06/17