| Class: | | | | | | | | | | | | ١ | /er | sio | n 1 | 1.0 | Sep | ter | mb | er 2 | 20 |
|--|---|--------------------------|------------|--------------|------------|-------------|--------------|----------|-----|--------------|------------|------------|-------------|--------------|------------|---------------|-------------------|------|--------------|-------------------|--------|
| | | | | | | | | | Da | ate | of | Bir | th: | : [| | | | | | | |
| Name: | School Roll Numbe | r: | | | | | | | | C | lie | nt l | D: | Ī | | | | | | | _ |
| | | | | | | | | | | | | | | | | | | | | | |
| Vaccination Co | onsent Fori | m | fc | r | C | h | ilc | dr | e | n | 8 | g | e | d | | |) | | | | |
| 2-12 Fluenz T | etra (LAIV) | n | a | sa | ıl | fl | u | V | a | C | cii | าเ | <u> </u> | | | 4 | 2 | | _ | 5(| |
| f you wish to give conser | • | | | | | | | | | | | | | a | ive | 2 C | an e | 201 | nt | | |
| please fill in parts 1 & 3. Foonsent for a child. Read | Please note only a pa | rent | or | ·le | ga | l gı | ıar | dia | n | ca | n c | 100 | าร | en | t c | r r | efu | ıse | • |) <u>.</u> | |
| Privacy Statement: In order to advaccine(s), the HSE will be procestyrarious data protection legislation Protection Regulation, GDPR), and | sing your child's personal c including the Data Protecti | data. <i>I</i> ion Ad | All d | lata 1988 | pro 3-2 | oces 018 | sec , the | by Re | the | e H lati | SE on (| will EU | be) 20 | in 016 | ac 6/67 | cord 79 (0 | dan Gen | ce v | with al D | n the | е |
| only be processed for specific pur validate clients and provide health | | | | | | | | - | | | | | or v | ac | cina | atio | n pı | rogi | ram | ıme | S |
| <u> </u> | | | | • | | | | _ | | | | | | | | | | | | | _ |
| PART 1 Personal | l Details Complete this | part | for | all | ch | ildı | en | (pl | ea | se | use | e b | loc | :k | cap | oita | ls) | | | | |
| Child's Forename: | | | | | | Mic | | | | | | | | | | | | | | | _ |
| | | 7 | | | | | | | | | | 1 | | | | | | | | | 1 |
| Child's Surname (Family Na | ıme): | _ | Ot | :hei | wi | se | kno | OW | n a | as: | | | | | | | | | | | |
| | ınındanını | | | | | | | | | | 1 | 1 | | | | | | | | | 1 |
| Child's Personal Public Ser | vices Number (PPSN): | : | | | | | П | | Ī | | ĪĒ | | | | | П | $\overline{\Box}$ | | | | Ī |
| PPSN will be required to manage | your immunisation record | only) | | | | | | | | | | | | | | | | | | | |
| Child's Date of Birth: | | | | | | | | | G | ien | de | r: | Ν | /lal | le | | | Fe | ema | ale | |
| Mother's surname at birth: | MM Y Y Y | | | | | | | | | 1 | 1 | 1 | ٦٢ | | | | | | | 1 | ٦ |
| Child's Address: | | | | | | | | | |] [_] [_ | 」 | | | | | П | Н | | | | ر 1 |
| | | $\exists \Box$ | | | | | П | | F | | | |] | | | | | | | | ر ا |
| | Cour | otv. | | | | | | | F | | |] [] [| | | | Н | П | | | | ر 1 |
| Child's Address when they | | ity. | Н | | | | | | | | | 」∟] [| 」∟ 7⊺ | | | Н | Н | | | | ر 1 |
| | | | | | | | | | H | | | 」∟ 1୮ | IJL IJſ | | | Н | Ш | | |] <u> </u>] [| ر آ |
| ululululululululu Parent/Legal Guardian Fore | name and Surname: | ᆛ屵 | | | | | Н | | L | | | 」 | IJL IJſ | _ | | Н | Н | | | | ر ٦ |
| 9 | | | | | | | | H | | | ↓∟ ┐┌ |]][| _ | ╡ | | \square | Н | H | |] <u> </u>] [| ر ٦ |
| Parent/Legal Guardian Day | | | I Ш I П | | | | | | | 」 □ | |] | | ╡ | | | Ш | | J | 」 □ | ر ٦ |
| Parent/Legal Guardian Mob | _ | | | | L | | Ш | | | JL | JL | JL | JL | | | | Ш | |] | | _ |
| Do you consent to receive t | | DOIL | nuri | ien | iS: | ſ | | | | 1 | 1 | 7 - | 7 | | | Y | es | | | No | ٦ |
| | | | | | | | | | | JL | JL | JL | JL | | | | Ш | |] |] <u> </u> | _ |
| Parent/Legal Guardian Ema | amalie andlit Vaccine a | anno | NINT | | | | | | | | | | | | | Y 6 | es | | | No | _ |
| Do you consent to receive of | | | ווונ | .1116 | 1113 | s? | | | | 1 | 1 | 7 - | 7 | | | | | Н | ' | 1 | -1 |
| _ | | | | | 1113 | s? | | | | | | | | | | Yea | | | | | |

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|---|---|--|
| Class: | | Date of Birth: |
| Name: S | chool Roll Number: | Client ID: |
| Choose Part 2 (YES | S) OR Part 3 (NO) | |
| PART 2 Please tick | each box and sign to say Y | YES |
| I understand that I am givingI confirm that I am authorise | the vaccine information includigons consent for the administration do to give consent on behalf of named child to receive the flu | n of Nasal Flu vaccine the above named child |
| Signature: | | Date: DDMMYYYY |
| Name (Please print): (Please tick): Parent | Legal Guardian | |
| Please answer the questions in I | Part 4 about your child | |
| OR PART 3 Please tick ea | ach box and sign to say NO | |
| I confirm by signing this form t | | ormation, including known side effects. nsent on behalf of the above named child. ed child with flu vaccine. |
| Signature: | | Date: DDMMYYYY |
| Name (Please print): | | |
| (Please tick): Parent | Legal Guardian | |
| Reason for Refusal: | | |
| PART 4 Screening qu | <u> </u> | |
| | • . | stions for your child. A member from the any of the information you have given. |
| • • | eive the flu vaccine from their G | GP or Pharmacist? Yes No |
| 2. Has your child ever had a se or vaccines? | evere allergic reaction to anythin | ing including medication Yes No |
| If yes, please provide details | | |

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|--|---|------------------------|----------------------|----------------|---------|
| Class: | | | Date of Birth: | | |
| Name: | School Roll Number: | | Client ID: | | |
| 4. Has your child | been diagnosed with asthma? | | | Yes | No 📗 |
| 5. If yes does you | ur child take regular steroids for the | heir asthma and/o | r has | | |
| your child ever | been admitted to ICU/Critical Ca | are for Asthma? | | Yes | No |
| - | d take aspirin/salicylates medicat | | | Yes | No |
| • | d have a severely weakened imm a/lymphoma or high dose steroids | - | | ment? Yes | No 🗌 |
| • | d live with anyone currently havin | • | | | |
| | system? e.g., someone who has h | | • | Yes | No |
| • | d take medication called combina ab plus nivolumab? | ation checkpoint ir | nhibitors | Yes | No 🗌 |
| _ | nown to have a condition causing | • | Fluid (CSF) leak | | |
| _ | r child had a recent cochlear imp | plant? | | Yes | No _ |
| • | receive the flu vaccine last year? | | | Yes | No |
| • | ever received the flu vaccine bef | | | Yes | No |
| i.e. absolute ne | d have severe neutropenia (low le eutrophil count <0.5 × 10 /L.? Thi Imune neutropenia. | | * | Yes | No 🗌 |
| dose of flu vaccine | ed under 9 years who have never e if they are at high risk of compli- pefore and is aged under 9 years, lowing conditions: | cations from infect | tion with flu. If yo | ur child has | never |
| Chronic heart d | isease | | | | |
| Chronic liver dis | sease | | | | |
| Chronic neurolo | gical disease | | | | |
| Chronic renal fa | ilure | | | | |
| Chronic respirat | tory disease (including cystic fibrosi | s, moderate or seve | ere asthma) | | |
| Diabetes mellitu | IS | | | | |
| Any condition the neuromuscular | nat might mean they cannot breathed disorder) | e well (e.g., a spinal | cord injury, seizure | e disorder, or | other |
| Down syndrome | е | | | | |
| Cancer | | | | | |
| Immunosuppres | ssion due to disease or treatment ir | ncluding asplenia or | hyposplenism | | |
| Moderate to severe to s | vere neurodevelopmental disorders | such as cerebral pa | alsy and intellectua | al disability | |
| Does your child ha | ave one or more of the conditions | listed above? | | Yes | No 🗌 |
| Before your child is | vaccinated you should let your vac | cinator know if you | r child: | | |
| has had influenz | za antiviral medications in the 48 ho | ours before their vac | ccine is due, they s | should not ge | et the |

- vaccine.
- has an acute exacerbation of asthma, including increased wheezing and/or needed additional inhalers in the previous 72 hours they should not receive the nasal flu vaccine.
- has gotten a dose of the flu vaccine from their GP or Pharmacist since the consent form was completed, they should not get the vaccine.
- is unwell with a sudden fever (as vaccination should be delayed until recovery).

You can contact the vaccinator by phoning them.

Please note that this vaccine is not suitable for people who are pregnant.

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|--|--|-----------------|-----------------|-------------------------|------------------------------------|-------------------|--|--|
| Class: | | | | | Date of Birth: | | | |
| Name: | | School Roll N | lumber: | | Client ID: | | | |
| Fluer | nz Tetra (LAIV) n | asal flu vacc | ine | | | | | |
| | Date Given | Batch Number | Prescribed | by signature CRN/PIN | Vaccinator's signa and PIN/MCRN | | | |
| | D D M M Y Y Y Y | | | | | Nostril Nostril | | |
| Clinic N | /accinated: Name: | AM/PM | | Vaccina | tion Location: Scl | hool Clinic | | |
| | eted by: | | MCRN | | | | | |
| | ne not administered e Contraindicated | please state wh | (if applied ny? | DNA or Ab | osent Re | efused on the Day | | |
| For c | official use on | ly | | | | | | |
| Notes | /Comments: | | | | | | | |
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