Nasal Flu Vaccination Consent Form for children aged 2-17 years (Fluenz LAIV)

2-17

COMPLETE THE FORM IN BLOCK CAPITALS USING A PEN.

Please complete the details in Parts 1-4. Please complete this consent form and return it in the envelope provided before the vaccinations begin.

Part 1: Child's Personal Details

Complete this part for all students (PLEASE USE BLOCK CAPITALS)

Child's Forename: Child's Middle Name:

Child's Surname (Family Name):

Otherwise Known As:

Child's Date of Birth:
D D M M Y Y Y Y

Mother's Surname at Birth:

Sex at Birth: Male Female

Child's Ethnic or Cultural Background:

A. White

A.1 Irish
A.2 Irish Traveller
A.3 Roma
A.4 Any other White background

B. Black or Black Irish

B.1 African
B.2 Any other Black background

C. Asian or Asian Irish

C.1 Chinese
C.2 Indian/Pakistani/Bangladeshi
C.3 Any other Asian background

D. Other, including mixed background

D.1 Arab
D.2 Mixed, write in description

Description

D.3 Other, write in description

Description

E. Prefer not to say

Child's Country of Birth:

Child's Personal Public Services Number (PPSN):

Child's Address:

Eircode:

County:

Child's Address when they last had a vaccine:

Class:

Year:

Class Name OR Number OR Letter:

FOR OFFICE USE ONLY

Version 2.0 September 2024

Name: Date of Birth:

Class: School Roll Number:

Part 2: Parent/Guardian Personal Details

Parent/Legal Guardian Forename and Surname:

Daytime Phone Number:

Mobile Phone Number:

Email:

If you tick yes to any of the child's Medical Details in Part 3 the Immunisation Team may need to contact you to discuss further. Please note we will send you an appointment confirmation and/or reminders by SMS and/or email.

PART 3: Child's Medical Details

1. Has your child already had a flu vaccine since 1 September 2024 — Yes ☐ No ☐

2. Has your child ever had a severe allergic reaction to anything including medication or vaccines? — Yes ☐ No ☐

If yes, please provide details __________

3. Has your child needed an Intensive Care Unit (ICU) admission following an allergic reaction to eggs? — Yes ☐ No ☐

4. Has your child been diagnosed with asthma? — Yes ☐ No ☐

4a. If yes does your child take regular steroids for their asthma and/or has your child ever been admitted to ICU/Critical Care for Asthma? — Yes ☐ No ☐

5. Does your child take aspirin/salicylates medication? — Yes ☐ No ☐

6. Does your child have a severely weakened immune system due to disease or treatment? e.g., leukaemia/lymphoma or high dose steroids or severe neutropenia — Yes ☐ No ☐

7. Does your child live with anyone currently having treatment that severely affects their immune system? e.g., someone who has had a bone marrow transplant? — Yes ☐ No ☐

8. Does your child take medication called combination checkpoint inhibitors e.g., ipilumumab plus nivolumab? — Yes ☐ No ☐

9. Is your child known to have a condition causing a Cerebrospinal Fluid (CSF) leak and/or has your child had a recent cochlear implant? — Yes ☐ No ☐

10. Has your child ever received the flu vaccine before? — Yes ☐ No ☐

11. Does your child have severe neutropenia (low levels of a type of white blood cell) i.e. absolute neutrophil count <0.5 × 10 /L.? This does not apply to those with primary autoimmune neutropenia. — Yes ☐ No ☐

FOR OFFICE USE ONLY

Name: __________ Date of Birth: __________

Class: __________ School Roll Number: __________

Part 4: Immunisation Consent

Medical Consent: Please note only a parent or legal guardian can provide consent for a medical procedure, or refuse consent for a medical procedure for young people under 16 years of age. Young people aged 16 years or older are legally entitled to consent for themselves. Read more about the HSE Consent Policy on the HSE website.

CONSENT TO VACCINATION:
Please tick one of the boxes below indicating whether you consent (tick yes) or refuse (tick no) the vaccination, and then sign this section.

☐ **YES**, I want my child to receive the flu nasal spray vaccination

☐ **NO**, I do not want my child to receive any flu vaccine

I have read and understand the accompanying vaccine information, including known side effects. ☐

I confirm by signing this form that I am authorised to give or refuse consent on behalf of the above named child. ☐

Name *(Please print)*: ______________________________

Signature: ______________________________

Date: D D M M Y Y Y Y

(Please tick): Parent ☐ Legal Guardian ☐ Self ☐

Thank you for completing the consent form. Please return in the envelope provided.

If you have consented to vaccination, please let your vaccinator know before the date of vaccination if your child:

- has had influenza antiviral medications in the 48 hours before their vaccine is due, they should not get 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 received a dose of the flu vaccine from their GP or Pharmacist since the consent form was completed.
- 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.

Privacy Notice: The HSE do not use consent as a lawful basis for processing personal data. In the interest of transparency, to explain how we collect and use personal information the HSE provides details within the HSE Privacy Notice for Patients and Service Users which is accessible via the HSE Privacy Statement. The processing of your child's data will be lawful and fair. It will only be processed for specific purposes including, to manage the vaccinations, to report and monitor vaccination programmes, to validate clients and provide health care. Data sharing between HSE departments may also occur.

Fluenz (LAIV) nasal flu vaccine

This young person assents to receiving the vaccine (Please tick) ☐

Prescriber's signature and MCRN/PIN	Vaccinator's signature and MCRN/PIN	Batch No.	Expiry Date	Vaccination Site		Date Given
			M M Y Y Y Y	Right Nostril	Left Nostril	D D M M Y Y Y Y

Time Vaccinated: **AM/PM** Vaccination Location: School ☐ Clinic ☐

Clinic Name:

Completed by: ______________________ **MCRN/PIN:** ______________________ D D M M Y Y Y Y

If vaccine not administered please state why? DNA or Absent ☐ Refused on the Day ☐

Vaccine Contraindicated ☐ Deferred ☐ Other ______________________

FOR OFFICE USE ONLY

Version 2.0 September 2024

Name: ______________________ **Date of Birth:** ______________________

Class: ______________________ **School Roll Number:** ______________________

For official use only

Notes/Comments:

FOR OFFICE USE ONLY

Version 2.0 September 2024

Name: Date of Birth:

Class: School Roll Number: