

INFLUENZA VACCINATION CONSENT FORM 2020 / 2021

PLEASE COMPLETE USING BLOCK CAPITALS IN BLACK INK



Sussex Community
NHS Foundation Trust

Before completing, please read the FAQ's attached to this form.

Please ensure ALL boxes marked (*) below are complete.

Any missing information may result in your child not being vaccinated on the day of the school session.

Legal SURNAME:*		Legal Forename:*		Date of Birth:*			Male <input type="checkbox"/>
				DD	MM	YYYY	Female <input type="checkbox"/>
Name known as, if different:				Ethnicity:			
Contact Telephone Number & Email Address for Parent or Guardian* <i>We may use to call, text or email regarding this vaccination</i>				Home Address: *			
				Postcode:*			
Email:							
GP Surgery Name & Town:*						NHS Number (if known)	
School:*				Year Group:*		Class Name:	

<i>Please complete ALL questions below by ticking either YES or NO</i>		YES	NO
Does the above named child have any severe allergies to egg, gentamicin or previous flu vaccination?*			
Is the above named child immunocompromised? E.g. undergoing treatment for Leukemia or in isolation.*			
Are any household members in isolation due to being immunocompromised? E.g. chemotherapy, bone marrow transplant. If so, avoid close contact with them for 2 weeks.			
I consent to the above named child's Digital Health (e.g. GP) Record being available to be viewed by SCFT staff involved in their care			

List ALL medication or inhalers taken by your child below.

Medication	Dose	Additional Information

Consent for Influenza Vaccination Programme (please complete **one** box only) *

YES, I CONSENT
for the above named child to receive the Influenza vaccine.
By signing this form I confirm the following statements:
I have parental responsibility for the above named child.
I have read and understood the information about the Influenza nasal vaccine.
I understand that this information will be held in the above named child's health record and shared with their GP.
Full Name of Person with Parental Responsibility
Signature of Person with Parental Responsibility:
Date:

NO, I DO NOT CONSENT
for the above named child to have the Influenza vaccine.
Please tick reason for declining below and return form to the school.
<input type="checkbox"/> My child has had the vaccine in the past four months. <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 (<i>please state</i>) use separate sheet if necessary
Full Name of Person with Parental Responsibility:
Signature of Person with Parental Responsibility:
Date:

