

CHILDREN'S NASAL FLU VACCINATION CONSENT FORM

Child's Name: _____

D.O.B. _____

Important Medical Information

Has your child had a confirmed severe egg allergy (needing hospital care)? Yes No

Is your child allergic to Gentamicin or Gelatin? Yes No

Does your child have any other allergies? Yes No

Has your child had a confirmed anaphylactic reaction to a previous flu vaccine? Yes No

Does your child have any long-standing medical conditions? Yes No

Does your child have a condition, or are they receiving treatment, that severely affects their immune system (e.g. Leukemia)? Yes No

Is anyone in your family/household currently having treatment that severely affects their immune system? Yes No

Is your child receiving salicylate therapy (e.g. Aspirin)? Yes No

Has your child had oral steroids (prednisolone) in the last 14 days? Yes No

Has your child received a flu vaccine before (either by injection or nasally)? Yes No

Has your child received a flu vaccine since September 2020? Yes No

If you answered yes to any of the above, please give details:

CONSENT

I consent to my child receiving a flu vaccination.

Signature of parent/guardian (with parental responsibility): _____

Relationship to child: _____

Date: _____
