Vaccination Consent Form for children aged 2-17
Fluenz Tetra (LAIV) nasal flu vaccine

If you wish to give consent, please fill in Parts 1, 2 and 4. If you do not wish to give consent, please fill in parts 1 & 3.

Please note only a parent or legal guardian can consent or refuse consent for for students.
Read more about consent on the HSE website https://bit.ly/ConsentU16.
Please return this form to your vaccinator as soon as possible.

Privacy Statement: HSE staff are aware of their obligation under the Data Protection Acts, 1988-2018 (including GDPR). The information provided will be included in an Immunisation Database. The HSE will use this information to validate clients, monitor vaccination programmes and provide health care.

Part 1: Personal Details

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

Child's Forename:

Child's Middle Name:

Child's Surname (Family Name):

Otherwise known as:

Child's Personal Public Service Number (PPSN):

Child's Date of Birth: DD/MM/YYYY

Gender: (please circle) Male Female

Mother's Surname at birth:

Child's Address:

Eircode: County:

Parent/Legal Guardian Forename and Surname:

Parent/Legal Guardian Daytime Phone Number:

Parent/Legal Guardian Mobile Phone Number:

Do you consent for getting texts about vaccine appointments? (please circle) Yes No

Parent/Legal Guardian Email Address:

Do you consent for getting emails about vaccine appointments? (please circle) Yes No

School: Class: Year:

Vaccination Consent Form for children aged 2-17
Fluenz Tetra (LAIV) nasal flu vaccine

For Office Use Only:

Client ID	Name	Date of Birth

Choose Part 2 (YES) or Part 3 (NO)

Part 2 Please tick each box and sign to say YES

- I have read and understand the vaccine information including the known side effects ☐
- I understand that I am giving consent for the administration of Nasal Flu vaccine ☐
- I confirm that I am authorised to give consent on behalf of the above named child ☐
- **YES**, I consent to the above named child to receive the flu vaccine. ☐

Signature: Date: DD/MM/YYYY

Name (Please print):

(Please tick): Parent ☐ Legal Guardian ☐

Please answer the questions in Part 4 on pages 3 and 4 about your child

OR

Part 3 Please tick each box and sign to say NO

- I have read and understand the accompanying vaccine information, including known side effects.
- I confirm by signing this form that I am authorised to refuse consent on behalf of the above named child.
- NO, I do not consent to the vaccination of the above named child with flu vaccine.

Signature: Date: DD/MM/YYYY

Name (Please print):

(Please tick): Parent ☐ Legal Guardian ☐

Reason for Refusal:

Vaccination Consent Form for children aged 2-17
Fluenz Tetra (LAIV) nasal flu vaccine

For Office Use Only:

Client ID	Name	Date of Birth

Part 4 Screening questions about your child

If you signed Yes in Part 2 please answer the following questions for your child.
A member from the vaccination team will contact you if they need to talk about any of the information you have given.

	Circle your answer	
Has your child already had a flu vaccine since September 2022 or does your child have an appointment to receive the flu vaccine from their GP or Pharmacist?	**Yes**	**No**
Has your child ever had a severe allergic reaction to anything including medication or vaccines? If yes, please provide details	**Yes**	**No**
Has your child needed an Intensive Care Unit (ICU) admission following an allergic reaction to eggs?	**Yes**	**No**
Has your child been diagnosed with asthma?	**Yes**	**No**
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**
Does your child take aspirin/salicylates medication?	**Yes**	**No**
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**
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**
Does your child take medication called combination checkpoint inhibitors e.g., ipilumumab plus nivolumab?	**Yes**	**No**
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**
Did your child receive the flu vaccine last year?	**Yes**	**No**
Has your child ever received the flu vaccine before?	**Yes**	**No**
Does your child have severe neutropenia (low levels of a type of white blood cell) i.e. absolute neutrophil count <0.5 × 10^9/L.? This does not apply to those with primary autoimmune neutropenia.	**Yes**	**No**

Vaccination Consent Form for children aged 2-17
Fluenz Tetra (LAIV) nasal flu vaccine

For Office Use Only:

Client ID	Name	Date of Birth

Part 4 Screening questions about your child

If you signed Yes in Part 2 please answer the following questions for your child.
A member from the vaccination team will contact you if they need to talk about any of the information you have given.

Some children aged under 9 years who have never had a flu vaccine before will need to have a second dose of flu vaccine if they are at high risk of complications from infection with flu.

If your child has never had a flu vaccine before and is aged under 9 years, they may need a second dose of flu vaccine if they have any of the following conditions:

- Chronic heart disease
- Chronic liver disease
- Chronic neurological disease
- Chronic renal failure
- Chronic respiratory disease (including cystic fibrosis, moderate or severe asthma)
- Diabetes mellitus
- Any condition that might mean they cannot breathe well (e.g., a spinal cord injury, seizure disorder, or other neuromuscular disorder)
- Down syndrome
- Cancer
- Immunosuppression due to disease or treatment including asplenia or hyposplenism
- Moderate to severe neurodevelopmental disorders such as cerebral palsy and intellectual disability

Does your child have one or more of the conditions listed above? (circle your answer) **Yes** **No**

Before your child is vaccinated you should let your vaccinator know if you child:

- has been taken 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 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.

Vaccination Consent Form for children aged 2-17
Fluenz Tetra (LAIV) nasal flu vaccine

For Office Use Only:

Client ID	Name	Date of Birth

FOR OFFICE USE ONLY

Administration Details

Influenza Vaccine				
Date Given	**Batch Number**	**Prescribed by signature and MCRN/PIN**	**Vaccinator's signature and PIN/MCRN**	**Confirm given intranasally (Add Yes to the box)**
Time Vaccinated:	**AM/PM**	**Vaccination Location**		

Completed by: **MCRN/PIN: (if applicable)**

Date: **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**

Notes/Comments:

Vaccination Consent Form for children aged 2-17
Fluenz Tetra (LAIV) nasal flu vaccine

For Office Use Only:

Client ID	Name	Date of Birth

FOR OFFICE USE ONLY

Notes/Comments: