





## Nasal Influenza (LAIV) Vaccination Consent Form

### Personal Details

Surname: \_\_\_\_\_ Phone No: \_\_\_\_\_  
 Forename: \_\_\_\_\_ Gender: \_\_\_\_\_  
 Address: \_\_\_\_\_ PPSN: \_\_\_\_\_  
 \_\_\_\_\_ GP Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ GP Address: \_\_\_\_\_

Medical History	Yes	No
• Is the patient aged 2-17 years?	<input type="checkbox"/>	<input type="checkbox"/>
• If under 9 years old and at-risk, has the child had any flu vaccination before?	<input type="checkbox"/>	<input type="checkbox"/>
• Is the child unwell in any way (fever or acute infection)?	<input type="checkbox"/>	<input type="checkbox"/>
• Is the child allergic to eggs or chicken?	<input type="checkbox"/>	<input type="checkbox"/>
• Has the child ever had an allergic reaction to any previous vaccination?	<input type="checkbox"/>	<input type="checkbox"/>
• Is the child allergic to any of the vaccine residues or excipients?	<input type="checkbox"/>	<input type="checkbox"/>
• Has the child ever suffered an anaphylaxis attack?	<input type="checkbox"/>	<input type="checkbox"/>
• Does the child have any problems with their immune system (e.g a stem cell/bone marrow transplant)?	<input type="checkbox"/>	<input type="checkbox"/>
• Does the child live with someone who is severely immunocompromised?	<input type="checkbox"/>	<input type="checkbox"/>
• Is the child taking aspirin/salicylate therapy?	<input type="checkbox"/>	<input type="checkbox"/>
• Has the child had an acute asthma attack in the last 3 days (or has needed inhalers more frequently)?	<input type="checkbox"/>	<input type="checkbox"/>
• Does the child require regular oral steroids or ICU care for asthma?	<input type="checkbox"/>	<input type="checkbox"/>
• Has the child had any antiviral medication in the last 2 days?	<input type="checkbox"/>	<input type="checkbox"/>
• Is the patient pregnant?	<input type="checkbox"/>	<input type="checkbox"/>

### Consent:

I have read and understood the nasal influenza vaccination leaflet and have been given an opportunity to speak to the pharmacist providing the vaccine.

- I understand:
- The nature of the treatment.
  - The risks of influenza.
  - The benefits and risks of immunisation.
  - The possible side effects of vaccination, when they might occur and how they should be treated.

I have been given an opportunity to ask questions and raise any concerns.

I agree that the details I have supplied have been recorded and those records will be kept by \_\_\_\_\_ pharmacy and shared with the HSE for the purposes of public health as required by legislation.

	Yes	No
I agree for my child to proceed with the nasal vaccination for influenza:	<input type="checkbox"/>	<input type="checkbox"/>
I agree for a copy of my child's vaccination record form to be sent to the GP:	<input type="checkbox"/>	<input type="checkbox"/>

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Name of Parent/Guardian \_\_\_\_\_  
 (not required if child is 16 years or older)

### Vaccination Details (for administration purposes only)

Vaccine Name: \_\_\_\_\_ Marketing Authorisation Number: \_\_\_\_\_  
 Date of Administration: \_\_\_\_\_ Batch Number: \_\_\_\_\_  
 Vaccine Dosage: \_\_\_\_\_ Expiry Date: \_\_\_\_\_  
 Vaccinating pharmacists name: \_\_\_\_\_ PSI number: \_\_\_\_\_  
 HSE funded vaccine