Please ensure you print out and complete the consent form prior to your appointment. If you are unable to print this document, it will be made available for you to complete at the Family Hub clinics.

Flu vaccination consent form

Flu can be very unpleasant for children and sometimes they end up in hospital. Vaccination helps protect your child against flu and reduces the chance of others catching flu from them. Most children are offered a nasal spray vaccine which is quick and easy to administer and is the preferred vaccine for children.

Please complete the questions below as a small number of children cannot have the nasal spray because of medical conditions or treatments. They can be offered protection through a vaccine injection instead.

The nasal spray vaccine contains a very small amount of gelatine from pigs (porcine gelatine) to keep the vaccine stable. If you do not accept medicines or vaccines that contain porcine gelatine, a flu vaccine injection is available that contains no gelatine. Please indicate on the form if you wish your child to have the alternative.

More information is available in leaflets found here: www.gov.uk/government/publications/flu-vaccination-leaflets-and-posters and from www.nhs.uk/child-flu

Child's full name (first name and surname)	Date of birth
Home address Postcode	GP name and address
Daytime contact telephone number for parent/carer Email address	NHS number (if known)
School / Nursery (if applicable)	Year group/class (if applicable)

Medical information (Please answer all questions)

1. Has your child already had a flu vaccination this season since 1 September 2025?	☐ Yes ☐ No
2. Does your child have a disease or treatment that severely affects their immune system? (e.g. treatment for leukaemia, high dose steroids)	☐ Yes ☐ No
3. Is anyone in your family currently having treatment that very severely affects their immune system? (e.g. they have just had a bone marrow transplant)	☐ Yes ☐ No
4. Has your child had any of the following: • a severe allergic reaction (anaphylaxis) to eggs requiring intensive care admission • confirmed severe allergic reaction (anaphylaxis) to a previous dose of flu vaccine • confirmed severe allergic reaction (anaphylaxis) to any component of the vaccine such as egg, neomycin gentamicin or polysorbate 80?	☐ Yes ☐ No
5. Is your child receiving salicylate therapy? (i.e. aspirin)	☐ Yes ☐ No
6. Has your child been diagnosed with asthma? If your child has asthma: i. Is your child prescribed regular oral steroid tablets for asthma? ii. Has your child ever been admitted to intensive care because of their asthma? **If your child has become wheezy, had an asthma attack or had to increase their use of reliever inhaler in the 3 days before vaccination is scheduled, please let the immunisation team know, either before, or on the day of vaccination.**	☐ Yes ☐ No
7. Are there any other medical conditions or recent/planned medical treatment that the immunisation team should be aware of?	☐ Yes ☐ No
8. If you answered Yes to any of the above questions, please give details	

Consent for flu vaccination (Please complete **one** box only)

☐ **YES, I want** my child to receive the flu nasal spray vaccination	☐ **YES, I want** my child to have the alternative flu vaccine injection	☐ **NO, I do not want** my child to receive any flu vaccine
If you have responded "yes" to any of the questions about medical conditions: I agree that if my child cannot have the nasal spray, they can be given a flu vaccine injection instead. ☐ Yes ☐ No ☐ N/A	If you have responded "yes", it would be helpful to understand why:	If you do not want your child to have the flu vaccine, it would be helpful to understand why:
Name Parent/Guardian		
Signature		
Date		
Any other comments		

Thank you for completing this form. Please bring the form along to your chosen clinic

OFFICE USE ONLY

Pre-session eligibility assessment for influenza vaccine	**Eligibility for LAIV assessment on day of vaccination[1]**
Child suitable for LAIV ☐ Yes ☐ No	Heavy nasal congestion on the day of vaccination ☐ Yes ☐ No
If LAIV not suitable, is child suitable for IIV ☐ Yes ☐ No ☐ N/A	If the child has asthma, has the parent/child reported: • use of oral steroids in the past 14 days? ☐ Yes ☐ No • has the parent/child reported the child being wheezy, having an asthma attack or needing more reliever inhaler over the past three days? ☐ Yes ☐ No
Additional information	
Assessment completed by (name, designation and signature)	Child eligible for LAIV ☐ Yes ☐ No If no, give details:
Date	

VACCINE DETAILS

Date	Time	Type of vaccine (please circle)		Site of injection, if applicable (please circle)		Batch number	Expiry date
		LAIV	IIV	L arm	R arm		

ADMINISTERED BY

Name	Designation	Signature
Site/Clinic:		
Date:		

1 Children with an acute exacerbation of symptoms including increased wheezing and/or needed additional bronchodilator treatment in the previous 72 hours should be offered inactivated vaccine to avoid a delay in vaccinating this 'at risk' group.