Child Health Service
Batley Health Centre
Upper Commercial Street
BATLEY
WF17 5ED
Tel 0303 003 4381
www.locala.org.uk

September 2020

Dear Parent/Guardian

Flu Vaccination for children in Reception to Year 6

This autumn school term, your child is being offered a flu vaccination through a nasal spray. This vaccination is offered in school to all children from Reception to Year 6 as part of a national health campaign to protect vulnerable people, including young children, from flu this Autumn and Winter.

The children's flu vaccination is given as a simple spray up the nose, which is painless, quick and very few children suffer any side effects. It means children are less likely to pass the virus on to friends and family, helping to protect those who are at greater risk including infants, older people and those with an underlying health condition. The vaccine provides protection against the types of flu that are predicted to circulate this year which is why we recommend vaccination every year.

To help you understand more about the vaccine:

- Here's a link to a leaflet about the flu vaccination http://bit.ly/childfluleaflet - this also includes information on children for whom the nasal spray is not appropriate. If you would like a hard copy of the leaflet posting to you, please ring the number above.
- For those who would like more details about the pork gelatine content of the vaccine please read the aleaflet and you can view a film of a GP discussing the vaccine at this link – https://bit.ly/vaccineGP

Please complete the enclosed consent form, whatever your decision, and return to school within 1 week, so your child can be included in the school session. Forms must be returned even if you DO NOT consent to the vaccination, explaining the reasons for your decision.

If your child becomes wheezy or has their asthma medication increased just before, or on the day of, the vaccination session, please contact the healthcare team on the number above.

If your child is absent/unwell on the day we are in school, we will return to school to carry out a follow up session or invite you to a clinic. If your child does receive this treatment from another source (i.e. GP Surgery/Clinic) in between these sessions – please contact the number above.

If you have any queries regarding this vaccination, please do not hesitate to contact our Immunisation Team on the number above.

We look forward to hearing from you.

Immunisation Team

Locala Community Partnerships CIC

NHS

CONSENT FOR NASAL FLU VACCINATION

Child's Name _____ **D.O.B** _____

Address: _____ **Sex** _____

Postcode_____ **Daytime Contact No** _____

School _____**Year Group** _____ **G.P** _____

IT IS VERY IMPORTANT THAT YOU ANSWER ALL THE QUESTIONS BELOW

1. Does your child suffer from any medical conditions, including asthma/allergies/anaphylactic reactions? **(An anaphylactic reaction is a severe and immediate allergic reaction to an immunisation that needs urgent medical attention which causes breathing difficulties and can cause collapse)** **If Yes give details:**	**YES/NO**
2.If your child suffers from asthma please state the medication and inhalers they are taking and the dose below **Medication details:**	**YES/NO**
3. Has your child been taking any medication for longer than a month in the last year? **If Yes give details:**	**YES/NO**
4. Has your child received any Immunisation recently? **If Yes give details:**	**YES/NO**
5. Has your child ever had a serious reaction to a previous immunisation? **If Yes give details:**	**YES/NO**
6. Does your child have a severe egg allergy (needing hospital care)? **If Yes give details:**	**YES/NO**
7. Has your child got a condition or are they receiving treatment that makes them immunosuppressed? **If Yes give details:**	**YES/NO**
8. Is your child or anyone in your family currently having treatment that severely affects their immune system (for example they need to be kept in special isolation)? **If Yes give details:**	**YES/NO**

I GIVE CONSENT

For my child to receive the Immunisation, and I have read and understood the information leaflet about Flu nasal spray

PRINT NAME _____ **Parent/carer**

Signed _____ **Parent/carer**

Date _____

FOR OFFICE USE ONLY

Sticker

Date _____ Time _____

Signature of Immuniser _____
Given in School/Clinic (please delete as applicable)

Patient Information Leaflet (PIL) given to patient/parent/carer YES/NO
School assisted with Identification of Child ☐

I DO NOT GIVE CONSENT

For my child to receive the immunisation.

PRINT NAME_____ **Parent/carer**

Signed _____ **Parent/carer**

Date _____

Please indicate the reason here. (please tick one)

Don't agree with the vaccination ☐ **Porcine content** ☐

Vaccinated already ☐ **Date** _____

Other reason ☐

Please give details _____

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