COLINTON SURGERY INFLUENZA IMMUNISATION CONSENT FORM 6 to 18 YR OLDS - 2020 **AT RISK**

*PLEASE NOTE THAT THIS FORM SHOULD BE COMPLETED WITH THE DETAILS OF THE PERSON WHO IS RECEIVING THE VACCINE AND **NOT** THE PARENT OR GUARDIAN'S DETAILS

Name* …… Date of Birth* ……

Contact Number……

	YES	NO
1. Is this your first ever flu vaccine	☐	☐
2. The person receiving the vaccine:		
is allergic to eggs	☐	☐
Is taking **ASPIRIN**	☐	☐
(IF YES PATIENT SHOULD NOT RECEIVE NASAL VACCINE)		
is severely immunodeficient or on immunosuppressant drugs	☐	☐
is pregnant or breastfeeding	☐	☐
has undergone an organ or bone marrow transplant	☐	☐
is in close contact with anyone who is immunocompromised	☐	☐
is suffering from severe asthma	☐	☐
or had an exacerbation of asthma requiring intensive care	☐	☐
IF YES VACCINATION SHOULD BE DISCUSSED WITH SPECIALIST		
has had anti-viral medication within past 48hrs	☐	☐
has your child had active wheezing in the last 72 hours	☐	☐
3. Does the person receiving the vaccine have asthma and use inhalers?	☐	☐
IF **YES** - Please complete the following questions:		
a) Have you difficulty sleeping because of asthma symptoms? Including cough	☐	☐
b) Have you had your usual asthma symptoms during the day (cough or wheeze or chest tightnes or breathlessness)?	☐	☐
c) Has your asthma interfered with your usual activities (housework, work or school etc)?	☐	☐

PLEASE TURN OVER