Pharmacy reference number ____________

PHARMACIST VICTORIA JONES
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Nasal Influenza (LAIV) Vaccination Consent Form

Personal Details

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

Medical History

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

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 benefits and risks of immunisation.
- The risks of influenza.
- 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:	❑	❑
I agree for a copy of my child's vaccination record form to be sent to the GP:	❑	❑

Signed by the pharmacist on behalf of the patient

Signature: ____________ Date: ____________

Name of Parent/Guardian ____________

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 ❑ Private vaccine ❑