Sundrive Medical Centre, 36 Sundrive Road, Kimmage, Dublin 12

LAIV (live attenuated influenza vaccine) Consent Form:

Child's Name:_____D.O.B._____

Please answer the questions and sign below:

1) Has your child ever received flu vaccine before? **Yes / No**

1) Does your child have asthma? **Yes / No**

If yes:

- Have they had increased use of their inhalers or increased wheezing in the previous 72Hrs? **Yes / No**
- Has your child ever required hospital admission for treatment of asthma? **Yes / No**
- Does your child take a regular oral steroid? **Yes / No**

2) Does your child take any aspirin containing medication? **Yes / No**

3) Has your child received medication for flu symptoms in the previous 48 Hours? **Yes / No**

4) Is your child or any member of the household classified as severely immunocompromised?

Yes / No

5) Does your child currently have a high temperature? **Yes / No**

6) Does your child have an egg allergy that has previously required hospital treatment?

Yes / No

I confirm by signing this form that I am authorising consent on behalf of the above named child. I consent for LAIV vaccine to be administered to my child.

Parent's/Guardian's name (PLEASE PRINT**):_____**

Signature:_____Date:_____

Vaccine administered by:_____Date:_____

PLEASE BE AWARE THAT THE NASAL FLU VACCINE CONTAINS GELATINE.

IF THIS IS OF CONCERN TO YOU, PLEASE DISCUSS WITH THE NURSE PRIOR TO ADMINISTRATION.