Childhood Influenza Consent

Patients Name: ________________________________

Date of Birth: ________________________________

If you tick yes to any of the following please discuss with the nurse / doctor.

		YES	NO
1	Anaphylactic reaction to a previous dose of influenza vaccine or any of its constituents (other than ovalbumin*).		
2	**Asthma:** ~ If an acute exacerbation of symptoms, increased wheeze and/or additional bronchodilator treatment in the last 72 hours. ~ Severe asthma, if on regular oral steroids or have had previous ICU care for asthma		
3	Significant immunosuppression due to disease or treatment		
4	Concomitant use of aspirin / salicylates.		
5	Influenza antiviral medications within the previous 48 hours.		
6	Live with severely immunosuppressed persons.		
7	Neutropaenia - to avoid an acute vaccine related febrile episode.		
9	Is your child currently suffering from an acute illness? (or as your child had a fever within the last 48hours?)		
10	Has your child been diagnosed with a condition caused by leaking of the cerebrospinal fluid?		
11	Has your child recently had a cochlear implant?		

***LAIV has an ovalbumin content less than 0.024 mcgs per 0.2ml dose. It can be given to children with confirmed egg anaphlaxis or egg allergy in a primary care setting. Children who have required critical care admission to hospital for a previous severe anaphylaxis to egg should be given LAIV in hospital.**
I consent for my child to be vaccinated with LAIV vaccine.
I have read and understand the accompanying vaccine information, including risks and side effects

Signed: ___________________________ Date:_________________________

Patient advised to wait 15 minutes in the vicinity of the clinic post administration of the vaccine.

Vaccination delivery site:	Nasal : Rt Deltoid: LT Deltoid:
Route of Administration:	IM:
Administered by Nurse:	Name______________________ Signature___________________
Checked & co-signed by Nurse/Doctor	Name:_____________________ Signature:__________________
Date Administered:	

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