THE ADAM PRACTICE

FLUENZ CONSENT FORM

CHILDHOOD IMMUNISATION - PARENTS INFORMED DECISION

The Adam Practice has provided me with information regarding the Paediatric Flu immunisation and I have been given the opportunity of discussing the risks and benefits.

Please Note: By signing this consent you confirm that you child does not have any of the following;

- Allergy to egg/egg proteins/gentamicin/gelatine
- Suffers with an impaired immune system
- Suffers with severe Asthma or active wheezing
- Taking any medication containing Aspirin or high dose oral steroids
- No fever in the past 24hrs

If your child has any of the above or you have concerns, please discuss with a nurse/doctor before consenting to immunisation.

If your child is under 16 years and will be accompanied by another family member (e.g. Grandparent) to obtain this immunisation, you MUST sign your consent below. Without this consent, we shall be unable to vaccinate your child until it has been obtained.

I wish my child (name): …… DoB: ……

to have the Paediatric Flu immunisation (via nasal spray), AND (where applicable) fully consent to The Adam Practice vaccinating my child whilst being accompanied by:

Name: ……Their relationship to Child: ……..

Signed (Parent/Guardian): …… Print Name: .....

Relationship to Child: …….. Date: ……