NHS
Essex Partnership University
NHS Foundation Trust

Dear Parent/ Guardian,

Your child's Annual Flu Vaccination Is Now Due

This vaccination is recommended to help protect your child against flu. Flu can be an unpleasant illness and sometimes causes serious complications. Vaccinating your child will also help protect more vulnerable family members and friends by preventing the spread of flu.

The vaccine is free and most children have it up their nose (nasal spray) which is quick and painless. **The nasal spray is the most effective vaccine for children**. If you do not wish for your child to receive the spray due to it containing porcine gelatine and would prefer for them to have the injectable vaccine, please contact us on the number provided below.

Please complete the attached consent form (one for each child) and fill in the box for the type of vaccine you want your child to receive. Please return the form to the school **within one week** to ensure your child receives their vaccination.

Since the programme was introduced, most children offered the vaccines in schools have had the immunisation.

If you have any queries, please contact the immunisation team on:

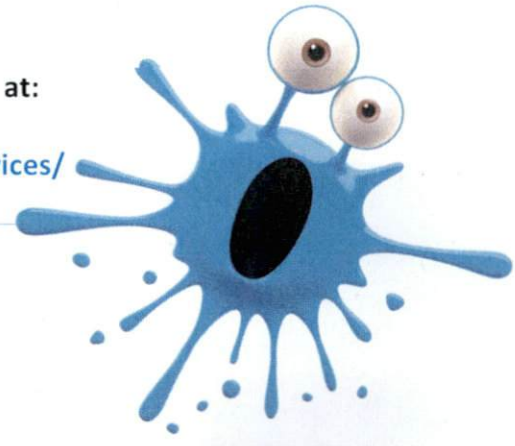
0300 790 0597 – Essex, Southend, Thurrock
0300 790 0594 – Bedford, Central Bedfordshire, Luton, Milton Keynes

Yours faithfully
Essex Partnership University Trust Immunisation Team

If your child becomes wheezy, has a bad asthma attack, or has started oral steroids for their asthma after you return this form, please contact the immunisation service on the number above.
If you decide you do not want to vaccinate your child against flu, please return the consent form giving the reason. This will help us to plan and improve our service.

For further information see: www.nhs.uk/child-flu

More information about your immunisation service is available at:
https://eput.nhs.uk/our-services/essex/essexwide/childrens/immunisation-and-vaccination-services/



Additional Information:
Possible Side Effects:

- decreased appetite
- headache
- nasal congestion (stuffy nose)
- aching limbs
- and a temperature

These side effects should pass quickly and can be treated with paracetamol/ibuprofen if you feel your child needs it. Children are most likely to experience side effects when they receive their first ever dose of the nasal Flu vaccine. Side effects normally reduce with doses in additional years.

The consent form needs to be signed by a person with parental responsibility which includes:

- **Mother**: automatic
- **Father:** if married to mother either when baby is born or marries subsequently
- **Unmarried father:** if name appears on birth certificate (since 01.12.03) or legally acquired
- **Others:** if parental responsibility is legally acquired
- **Parental Responsibility Agreement:** signed, properly witnessed and sent for registration to Principle Registry or the Family Division (High Court)
- **Residence Order:** granted by the Court

Immunisation Service Privacy Notice - May 2018
Who is collecting the data?
Essex Partnership University Trust Immunisation Service is collecting information about your child to ensure that we have up to date health information about their health at the time that you are consenting for them to receive an immunisation. Their demographic information is used to ensure that we identify their electronic health record accurately.

What data is being collected?
We ask for basic demographic data to allow us to identify them and their health record. The information about their health is utilised by the nurses to ensure that they can confirm that the immunisation is suitable for them.

What is the legal basis for processing the data?
Section 9(2)(h) allows for the processing of your child's data for the provision of direct healthcare and the management of healthcare systems.

Will the data be shared with any third parties?
Your child's data will be shared with their general practice (GP) and with the child health information system (CHIS) which holds immunisation and screening information for all children in the UK.

How will the information be used?

We collect data on consent forms to allow us to identify a person's health record if you have consented to their immunisation and to allow the nurses to make decisions about their care based on the most up to date information about their current health.

How long will the data be stored for?
The information will be stored on their electronic health record after their vaccination; this information will then be available throughout their lifetime. Their paper records will be destroyed once they have been scanned onto their record.

What rights does the data subject have?
Data subjects have the right to request a copy of any data we request or record about them.

How can you contact us with queries or concerns about this privacy notice?
If you have any queries or concerns regarding the information that we hold about your child or have a question regarding this privacy notice, please contact:

Our Data Protection Officer: Epunft.dpo@nhs.net **Tel: 01268 407724**

Or the Information Governance team: Epunft.info.gov@nhs.net

Or the Information Commissioner Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF
Web: https://ico.org.uk/concerns/ **Tel: 0303 123 1113**

Triaged ◯ | FAO Nurse ◯ | 2nd Dose Required ◯

Flu Immunisation Consent Form (Fluenz)

NHS
Essex Partnership University
NHS Foundation Trust

Please complete in BLACK INK and return to your child's school.
Consent forms can be returned in a sealed envelope.

Child's details

Child's full name (first name and surname):

Other names child is known by:

Home address:

NHS number (if known):

School: Year group/class:

Date of birth:

Gender (circle as appropriate): **Male Female**

Daytime contact telephone number(s) for parent/carer:

Consent to text (circle as appropriate): **Yes No**

GP name and address:

Important information about this immunisation - ALL CHILDREN

1) Please tick if your child has already received the flu vaccination since September this year. *Yes ☐ No ☐
2) Has your child ever received a flu vaccine before? Yes ☐ No ☐
3) Does your child have any long standing medical conditions and/or is taking medication, especially salicylate therapy (i.e. aspirin) or steroids? *Yes ☐ No ☐
4) Is your child's immune system severely affected by a condition or medicines they are receiving? (For example they have leukaemia or are taking Azathioprine) *Yes ☐ No ☐
5) Is anyone in your family, or anyone you have regular contact with, currently having treatment that severely affects their immune system? (For example they need to be kept in isolation) *Yes ☐ No ☐
6) Has your child ever had a very severe allergy that has required admission to an intensive care unit at a hospital (such as to eggs)? *Yes ☐ No ☐

*** If you answered Yes to any of the questions above PLEASE GIVE DETAILS:**

Important information about asthmatic children (you only need to complete this if your child has asthma)

Has your child ever been in an intensive care unit at a hospital because of their asthma? *Yes ☐ No ☐

Does your child take regular steroid tablets for their asthma or have they taken them in the past 14 days? *Yes ☐ No ☐

*** If you answered Yes to either of these questions PLEASE GIVE DETAILS:**

(If you would prefer your child not to see this information, please return the form to the school in a sealed envelope with a note asking us not to give it to them)

Consent for immunisation (Please complete)

YES, I consent for my child to receive the Fluenz immunisation

Name (print): .....

Signature of parent/guardian *(with parental responsibility):* .....

Relationship to child: .....

Date: .....

NO, I DO NOT consent for my child to receive the Fluenz immunisation

Reason: .....

Name (print): .....

Signature of parent/guardian *(with parental responsibility):* .....

Relationship to child: .....

Date: .....

NB. The nasal vaccine contains porcine gelatine. There is no suitable alternative vaccine available for otherwise healthy children.

Please return this form completed to school. If we do not receive a form your child WILL NOT be vaccinated

Scanned ◯ | Input ◯

FOR OFFICE USE ONLY

Additional Information:

ID Confirmed by:

Eligibility assessment ON DAY of vaccination

CRITERIA - INELIGIBILITY	YES	NO
Acute febrile illness		
Confirmed anaphylaxis to a previous dose of flu vaccine		
Confirmed anaphylaxis to any component of LAIV (e.g. gelatine) or residue from the manufacturing process (e.g. gentamicin) with the exception of egg proteins (see PGD)		
Severe anaphylaxis to egg which has previously required intensive care		
Clinical immunodeficiency due to conditions or immunosuppressive therapy (Children with HIV infection who are responding to highly active antiretroviral therapy (HAART) can receive LAIV)		
Close contact with very severely immunocompromised patients is likely or unavoidable		
Concomitant use of anti-viral therapy for influenza or less than 48 hours since stopping anti-viral therapy		
Receiving salicylate therapy (other than topical treatments for localised conditions)		
Unrepaired craniofacial malformations		
Severe asthma that has previously required intensive care for an asthma exacerbation or who require regular oral steroids for maintenance of asthma control (e.g. currently taking or who have taken oral steroid in past 14 days), unless LAIV is advised by their respiratory specialist		
Current exacerbation of asthma- increased use of bronchodilators or wheezing in past 72 hours		

(If child not immunised) reason:

☐ Not well enough today ☐ Allergies ☐ Asthma ☐ Absent ☐ Other reason:

☐ Child refused (none given) ☐ Child refused (partially given) ☐ Right Nostril ☐ Left Nostril

Name: ..... Signature .....

Designation: ..... Date: .....

Details of Supply and/or Administration of Fluenz Tetra Vaccine

Date:	Time:	Batch number:	Expiry date:

Venue where administered: School ☐ Clinic: .....

Advice on side effects provided: **YES** ☐ **NO** ☐

Accredited written management advice provided: **YES** ☐ **NO** ☐

Child identified for 2nd dose: **YES** ☐ **NO** ☐ **TBC** ☐

Child is under 9 years old and in one of the following clinical risk groups:

Chronic respiratory disease/active wheezing: Chronic heart disease, chronic liver disease, chronic kidney disease, chronic neurological disease, diabetes, immunosuppression.

If the answer is YES, two doses required (unless they have had the vaccine already) follow up appointment required.

Supplied under PGD by (complete if appropriate):

Name: ..... Signature: ..... RN ☐

Administered (under PGD/by HCA):

Name: ..... Signature: .....

Designation: .....

NOTES: *(Please enter name, date and sign against each entry)*