Dr CARMEL WHITFORD
FAMILY PRACTICE

CHILD INFLUENZA VACCINATION CONSENT FORM

FIRST NAME	
SURNAME	
DATE OF BIRTH	
GENDER	
MOBILE NUMBER (PARENT/GUARDIAN)	
EMAIL ADDRESS (PARENT/GUARDIAN)	

Please complete the following questions before signing the Consent Form for your child. **(PLEASE TICK)**

1. Is your child suffering from an acute illness? **YES** **NO**
   If yes, please detail.

2. Has your child been wheezy or used an Inhaler in the last 72hrs? **YES** **NO**
   If yes, please detail.

3. Does your child have any severe allergies to food such as egg or any medicines including vaccines? **YES** **NO**
   (e.g previous **LIFE THREATENING** allergic reactions)
   If yes, please detail.

4. Has your child taken Asprin in the last 48hrs? **YES** **NO**
   If yes, please detail

5. Has your child any illness or condition that increases the risk of bleeding?
   If yes, please detail. **YES** **NO**

6. Does your child live with anybody having chemotheraphy or with a compromised immune system?
   If yes, please detail. **YES** **NO**

I consent to the Flu Vaccination of my child.

Signature Parent/Guardian _____

Date _____ DD/MM/YY

PLEASE COMPLETE THIS FORM AND BRING IT WITH YOUR CHILD ON THE DAY OF THE VACCINATION.