Bournbrook Varsity Medical Centre

1A Alton Road, Selly Oak, Birmingham B29 7DU
Tel: 0121 472 0129

Open Monday to Saturday
Dr C Allen - Partner, Dr M Swallow - Partner
Dr M Philp, Dr A Nijjar, Dr H Cole, Dr S Ali, Dr S Clarke, Dr J Tatlock, Dr N Ahmad, Dr A Dungate, Dr N Grant - Associates

Title Initial Last Name
Home Address House Name/Flat Number
Home Address Number and Street
Home Address Village
Home Address Postcode

INVITATION FOR SEASONAL FLU VACCINATION

As I am sure you are aware flu can be a nasty illness. Protecting against this can reduce the likelihood of you catching flu and will stop it from spreading to others who may be particularly at risk.

There is a safe and effective nasal spray vaccine called Fluenz Tetra (LAIV) which protects under 18's against flu. The vaccine is the most effective vaccine for children and is easy to give and painless.

Please telephone the surgery on 0121 472 0129 to make an appointment into a clinic and let the receptionist know it is for a "children's flu vaccination".

For more information on this please go to: https://www.nhs.uk/conditions/vaccinations/child-flu-vaccine/

On the reverse of this letter you will find a proforma **please bring this with you**. If you can answer any of the questions we would be very grateful as this will save time during your visit. We look forward to seeing you and your child.

Fluenz Tetra is the most effective vaccine for children; however we are aware that some under 18s may wish to receive a vaccine that does not contain porcine gelatine. If you would prefer to receive a vaccine without this content please let us know when you call to book an appointment.

If you/ your child does not wish to be vaccinated this season please let us know so that we can remove you/ your child from our recall list for this year.

Yours sincerely

Dr C Allen

CHILDRENS INFLUENZA

CHILDS NAME: **Date of Birth:** **Ethnicity:**

Allergies:

Has your child had a severe (anaphylactic) allergic reactionto any previous vaccines? ☐ Yes ☐ No

If yes please specify: ………………………………………..

…………………………………………………………………

Does your child have a confirmed egg allergy? ☐ Yes ☐ No

Asthma:

Does your child have asthma? ☐ Yes ☐ No

If yes, please tick level of their disease:
☐ Mild ☐ Moderate ☐ Severe

And record the daily medications they take for asthma:

………………………………..…………………………………

……………………………………………………………………..

Immunosuppressed:

Has your child got a condition or are they receiving treatment that makes them immunosuppressed? ☐ Yes ☐ No

If yes, please provide details: ………………………………

…………………………………………………………………

Is anyone in your family currently having treatment that severely affects their immune system? ☐ Yes ☐ No

If yes, please provide details: ………………………………

…………………………………………………………………

Medication:

Is your child receiving salicylate therapy (ie aspirin)? ☐ Yes ☐ No

If yes, please provide details: …………………………………

…………………………………………………………………

Is your child on any other regular medication? ☐ Yes ☐ No

If yes, please provide details: …………………………………

…………………………………………………………………

MMR Vaccine:

Has your child had an MMR vaccination in the last four weeks or are they due one soon? ☐ Yes ☐ No

Consent for immunisation for my son/daughter to receive the flu nasal spray

Yes I consent ☐

Name: Signature of parent /guardian/carer:

**** Staff Only Section****

Suitable for FLUENZ Nasal Vaccine
Flu Vacc Given [ ]
Left nostril [ ] Right nostril [ ]
Refused [ ] Unsuitable [ ] Reason:……………………………………………………………………………………

PLEASE LEAVE THIS FORM WITH THE NURSE / HCA / DOCTOR AFTER YOUR VACCINATION THANK YOU

If you do not wish your child to have the seasonal influenza please sign and return the disclaimer below

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CHILDS NAME: ____ DOB: _____________________

PARENTS NAME: ____ DOB: _____________________

I do not wish my child to have the seasonal influenza vaccination this season (2023) ☐ *(please tick if applicable)*

Signed: ………………………………………………………………… Date: ………......................