Bournbrook Varsity Medical Centre

1A Alton Road, Selly Oak, Birmingham B29 7DU
Tel: 0121 472 0129
Open Monday to Saturday
Dr C Allen, Dr M Swallow, Dr A Dungate, Dr S Clarke - Partners
Dr M Philp, Dr A Nijjar, Dr H Cole, Dr S Ali, Dr J Tatlock, Dr N Ahmad, Dr N Grant, Dr E Al-Shammary - Associates

Title Initial Last Name
Home Full Address (stacked)

Annual flu vaccination due for your child

This vaccination is recommended to help protect your child against flu. Flu can be an unpleasant illness and sometimes causes serious complications. Children under the age of five years have one of the highest rates of hospital admissions due to flu.

Vaccinating your child will also help protect more vulnerable friends and family by preventing the spread of flu.

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

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.

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.

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

Bournbrook Varsity Medical Centre

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 (2026-27) ☐ *(please tick if applicable)*

Signed: …… Date: ……