

Patient Name: _____

Date of Birth: ____/____/____



Chart #: _____

Age: _____

Consent for Flu Vaccine

(All Formulations)

*I understand that the above named patient will not be examined by a doctor today, as he/she is in good health and is **NOT** sick.*

I have read the information about the Flu Vaccine and truthfully answered all of the questions on this form. I have also received a copy of the Vaccine Information Statement. I have had a chance to ask questions and fully understand the benefits and risks of vaccination with the Flu Vaccine. My signature below indicates my permission for the Influenza (Flu) Vaccine to be given to the patient named above.

For Patient's \geq 18 years old: Patient Signature: _____

For Patient's < 18 years old: Parent Guardian Name: _____

Signature of Parent or Guardian: _____ Date: _____

Form Administered By: _____ **Date:** _____

Pediatric Associates

FluMist® Screening Form (Influenza Virus Vaccine Live Seasonal &/or H1N1 Intranasal)

The following questions will help us to determine if the patient named above is able to receive FluMist Seasonal and/or Flumist H1N1 Intranasal vaccine today.

Only people 2 years of age and older may qualify.

Do any of the following apply to the patient receiving the vaccine today? (Please check all that apply)

- Currently sick
- Asthma
- Experienced wheezing more than once in the past 12 months
- Experienced Guillain-Barré syndrome
- Long-term health problem with weakened immune system (e.g., HIV) or chronic heart, lung, kidney or metabolic disease (e.g., diabetes)
- Sickle cell disease or other severe anemia or blood disorder
- Seizure disorder or other neuromuscular disorder
- Pregnant or nursing
- Allergy to eggs or egg proteins, gentamicin, gelatin, or arginine
- Life-threatening reactions to any influenza vaccine in the past
- Currently receiving aspirin or aspirin-containing therapy
- Received any other vaccinations in the past 4 weeks

(If **any** of the above was checked, the patient named above **may not** be able to receive FluMist/ H1N1 Intranasal).

Within the next 7 days, do you expect the patient named above to have close contact with someone whose immune system is so severely compromised that they must be kept in isolation? (i.e., hospitalized after a transplant).

Yes No

*(If the answer is YES, the patient **cannot** receive FluMist or H1N1 Intranasal)*