

Palm Beach Pediatrics
Vaccination Consent Form for FluMist
(Influenza Virus Vaccine Live, Intranasal)

Before you can receive FluMist, you must read this information sheet, answer the questions and ask your health care professional administering the vaccine to review your answers. FluMist should only be administered to children and adolescents 2-17 and adults 18-49 years old who are healthy and NOT pregnant. Not indicated for children less than 2 years of age. Certain people must not receive FluMist. **You must answer each question below, and have the answers reviewed by the health care professional to ensure you are eligible to receive FluMist.** The health care professional will keep this questionnaire and any information collected in a confidential manner. There are risks associated with all vaccines, including FluMist. Like any vaccine, FluMist does not protect 100% of individuals vaccinated. In studies, side effects were generally mild and temporary. Runny nose was the most common. Other common side effects included various cold-like symptoms, such as headache, cough, sore throat, tiredness/weakness, irritability, and muscle aches.

Birth date: _____ Have you had a flu vaccination in the past? Y or N Phone Number: _____

Precautions and Contraindications: Please mark YES or NO for each question. YES NO

Are you over the age of 49? _____

Are you allergic to eggs? _____

****I have a known allergy to eggs and want to receive the flu vaccine. The risks have been explained to me.** _____

Has a doctor ever told you that you have an immune system disorder? _____

Do you have AIDS, HIV, Cancer or have you received an organ transplant? _____

Do you have a history of asthma, reactive airway disease, wheezing or chronic respiratory problems? _____

Do you have any disease of the lungs, including chronic bronchitis, emphysema, or cystic fibrosis? _____

Did you ever have Guillian-Barre syndrome? _____

Do you have kidney disease? _____

Are you pregnant? _____

Do you have heart disease (angina, congestive heart failure) or have you ever had a heart attack or stroke? _____

Do you have blood disease like sickle cell disease or thalassemia? _____

Do you currently have a respiratory illness or a fever? _____

Have you received any vaccines within the last month or do you plan to receive any within the next month? _____

Are you taking any prescription medicines to prevent or treat influenza? _____

If you are under 18 years of age, are you currently receiving aspirin or Aspirin-containing therapy? _____

Do you have diabetes or other metabolic disease? _____

Does anyone living with you have a compromised immune system? _____

Are you in close contact with severely immunocompromised individuals requiring a protective environment (such as bone marrow transplant recipients)? _____

If you answered yes to any of the above, we **will not** be able to administer FluMist to you today. Please see your family physician. If you have a reaction after getting FluMist, you should see your physician right away.

I have read the above information about FluMist and have truthfully answered all of the questions on this form. I have also received a copy of the Vaccine Information Statement on FluMist. I have had a chance to ask questions and fully understand the benefits and risks of vaccination with FluMist. My signature below indicates my permission for FluMist to be given to me. I **will not** hold Palm Beach Pediatrics responsible for any adverse reactions due to the FluMist vaccine.

Your child's full name: _____ Your name: _____

Address: _____

Patient/ Parent Signature _____ Date _____ Signature of Provider _____ Date _____

For Nursing staff only:

Temp: _____ VIS given FluMist given on: Date _____ Lot # _____ Initials: _____