

Nursing Vaccination Specialists, Inc.

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 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 or nursing?

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, your physician will have to determine if FluMist is right for you. 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 or 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.

Name: _____

FluMist given on: Date _____ Lot # _____

Address: _____

Print Patient Name / Parent Signature

Date

Signature of HCP

Date