# INFLUENZA CONSENT FORM

## FLU SHOT AND FLU MIST

Patient Name:_____ Date of Birth:_____ AGE:_____

Address: _____ Phone: _____

Insured Name: _____ Insured's Date of Birth: _____

| | YES | NO |
|---|---|---|
| 1. Does the patient have a serious allergy to eggs? | ___ | ___ |
| 2. Does the patient have any other serious allergies? | | |
| a. Please list: _____ | ___ | ___ |
| 3. Has the patient ever had serious reaction to a previous dose of flu vaccine? | ___ | ___ |
| 4. Has the patient ever had Guillain-Barre Syndrome (a type of temporary severe muscle weakness within 6 weeks of receiving a flu vaccine? | ___ | ___ |

**Flumist is an intranasal, live, attenuated Flu vaccine FDA approved for people between 2yrs and 50 yrs old. Please answer the following questions if you desire Flumist:**

| | | |
|---|---|---|
| 5. Has the patient been vaccinated with any vaccine (not just flu) within the past 30 days? Vaccine_____ Date Given_____ | ___ | ___ |
| 6. Does the patient have any of the following: asthma, diabetes, lung, heart kidney, liver, nerves or blood diseases? | ___ | ___ |
| 7. Is the patient on long-term aspirin or aspirin-containing therapy? | ___ | ___ |
| 8. Does the patient have a weak immune system (ex. HIV, Cancer, Immune suppressant medications such as steroids, chemotherapy)? | ___ | ___ |
| 9. Is the patient pregnant? | ___ | ___ |
| 10. Does the patient have close contact with a person who needs care in in a protected environment (ex. Bone marrow transplant)? | ___ | ___ |

### Consent for Vaccination

I have read or had explained to me the Vaccine Information Statement for the seasonal influenza vaccine and understand the risks and benefits. By signing this consent, I agree to take financial responsibility for the cost of the service or a portion of the cost of the service according to my health insurance coverage.

____ I Give Consent to **Bristow Pediatrics** and its staff for the patient named at the top of this form to be vaccinated with this vaccine. If this consent form is NOT signed then the patient will NOT be vaccinated.

____ I DO NOT GIVE CONSENT to **Bristow Pediatrics** and its staff for the patient named at the top of this form to be vaccinated with this vaccine.

Signature of Patient/Parent/Legal Guardian_____Date_____

**FOR ADMINISTRATIVE USE ONLY**
VACCINE: IM_____ FLU MIST_____
DATE ADMINSITERED_____
VACCINE MANUFACTURER_____ LOT NUMBER_____EXP DATE_____
SITE OF INJECTION: DELTOID R L ANTEROLATERAL THIGH R L
NAME AND TITLE OF VACCINE ADMINISTRATOR_____