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INFLUENZA IMMUNIZATION CONSENT & WAIVER

DATE: _____

PATIENT: _____

Consent for Immunization:

I have received a copy of the Vaccine Information Statement for Influenza. I understand the risks of the influenza disease which this vaccine prevents. I understand the risks and benefits of receiving this vaccine. I have had a chance to ask any questions.

I am an adult who can legally consent for the person named above to get this vaccine, and I freely and voluntarily give my signed permission for this vaccine to be given.

Waiver:

I agree to pay for my child's Flu Shot/Flu Mist today by cash, check, or credit card during my physician's designated Flu Shot Clinic. I understand that my insurance company will not be billed for this service.

If my child requires a 2nd dose of Flu vaccine, an appointment will be made at the time the 1st dose is given, and that a 2nd dose will be held in his/her name for no more than 45 days. If we fail to keep this 2nd appointment, I understand that this dose will then be given to another child.

I also understand that in the situation of a vaccine shortage, my physician must use his/her discretion in giving any reserved doses to those that need it most.

Signature of patient or person authorized to give consent for this immunization:

Signature	Printed Name	Date
FLUZONE IM inj. 0.25 ml FLUZONE IM inj. 0.5 ml Flumist intr. 1st DOSE 2nd DOSE	Y N HX OF G-B SYNDROME Y N ALLERGY TO CHICKEN FEATHERS/EGGS Y N HX OF SEIZURES	

Physician's Signature	Date
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LAIV (FluMist) Screening Questionnaire

Name: _____

Age: _____

Live, attenuated intranasal vaccine (LAIV) FluMist should only be administered to healthy children and adolescents 2-17 years old and healthy adults 18-49 years of age. Certain people must **NOT** receive FluMist. Please answer each question below to determine if FluMist is right for you.

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

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|--|-----|----|------------|
| 1. Are you allergic to eggs? | YES | NO | DON'T KNOW |
| 2. Do you have any problems with your immune system? | YES | NO | DON'T KNOW |
| 3. Did a doctor ever tell you that you had asthma or reactive airway disease? | YES | NO | DON'T KNOW |
| 4. Do you have AIDS, HIV, cancer, or have you received an organ transplant? | YES | NO | DON'T KNOW |
| 5. Do you have any disease of the lungs, including chronic bronchitis emphysema or cystic fibrosis? | YES | NO | DON'T KNOW |
| 6. Did you ever have Guillain-Barre syndrome or active neurological disease? | YES | NO | DON'T KNOW |
| 7. Do you have kidney disease? | YES | NO | DON'T KNOW |
| 8. Are you pregnant or nursing? | YES | NO | DON'T KNOW |
| 9. Do you have heart disease (angina, congestive heart failure) or have you ever had a heart attack or stroke? | YES | NO | DON'T KNOW |
| 10. Do you have a blood disease like sickle cell disease or thalassemia? | YES | NO | DON'T KNOW |
| 11. Do you currently have a cold or other respiratory illness or a fever? | YES | NO | DON'T KNOW |
| 12. Have you received any vaccines within the last month or do you plan to receive any within the next month? | YES | NO | DON'T KNOW |
| 13. Are you taking any prescription medicines to prevent or treat the flu? | YES | NO | DON'T KNOW |
| 14. Does anyone living with you have a compromised immune system? | YES | NO | DON'T KNOW |
| 15. Do you have diabetes or other metabolic disease? | YES | NO | DON'T KNOW |
| 16. Are you well today? | YES | NO | DON'T KNOW |