Seasonal FluMist® (Influenza Virus Vaccine Live, Intranasal)
Vaccination Consent Form – Parent or Guardian

Before your child can receive seasonal FluMist®, you must read this information sheet, answer the questions, and ask the health care professional administering the vaccine to review your answers. FluMist® should only be administered to children and adolescents 2-17 years old and adults 18-49 years old who are healthy and not pregnant. Certain people must not receive FluMist®. **You must answer each question below, and have the answers reviewed by the health care worker to ensure your child is eligible to receive seasonal FluMist®.** Our office 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 of people between the ages of 2 and 49, 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.

How old is your child? _____

Precautions and Contraindications: Please mark YES or NO for each question.	**Yes**	**No**
1. Is your child sick today?	☐	☐
2. Is your child allergic to eggs or a component of the influenza vaccine?	☐	☐
3. Has your child ever had a serious reaction to intranasal influenza vaccine (FluMist) in the past?	☐	☐
4. Does your child have a long-term health problem with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., diabetes), or anemia or another blood disorder?	☐	☐
5. If your child is ages 2 through 4 years, in the past 12 months has a healthcare provider ever told you that he or she had wheezing or asthma?	☐	☐
6. Does the person to be vaccinated have cancer, leukemia, HIV/AIDS, or any other immune system problem; or in the past 3 months, have they taken medications that weakens the immune system, such as cortisone, prednisone, other steroids, or anticancer drugs; or have they had radiation treatments?	☐	☐
7. Is the person to be vaccinated receiving antiviral medications?	☐	☐
8. Is your child receiving aspirin therapy or aspirin-containing therapy?		
9. Is your child pregnant or could she become pregnant in the next month?		
10. Has your child ever had Guillain-Barre syndrome or active neurological disease?	☐	☐
11. Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g., an isolation room of a bone marrow transplant unit)?	☐	☐
12. Has your child received any other vaccinations in the past 4 weeks?	☐	☐

If you answered yes to any of the above, your physician will have to determine if FluMist® is right for your child. If you have any questions about the benefits and risks of vaccination with FluMist®, please contact _____.

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 for 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 the child named below, and I am the Child's parent or legal authority with authority to consent to vaccination.

_____ FluMist® Given: *Date* _____ *Time* _____ *Lot Number*_____
Printed Name of Person to Receive Vaccine

_____ _____ _____
Printed Name of Parent or Guardian *Signature of Parent or Guardian* *Date*

Where to Report Adverse Reactions (Side Effects):
If your child has a reaction after getting FluMist®, you should contact your pharmacist or physician right away. You are encouraged to report any reaction from the vaccine to the FDA (Food and Drug Administration) using the Vaccine Adverse Event Reporting System (VAERS) form available at https://secure.vaers.org/VaersDataEntryintro.htm. The VAERS reporting form and instructions for submitting it can be obtained by calling toll-free 1-800-7967 or by toll-free fax at 1-877-721-0366

Office Use Only: I have reviewed the above information.

_____ _____ _____
Print name of staff member *Signature of staff member* *Today's Date*