Arapahoe Park Pediatrics

7780 South Broadway Suite 220 Littleton, CO 80122

Flu Vaccine Consent Form

"I have been provided with vaccine information material. I believe I understand the benefits and risks of the vaccines cited and ask that the vaccine(s) below be given to me or to the person named below for who I am authorized to make this request. Furth by signing this form, you are stating that you have read and agree with the information that is written on this form."

Patient's Name	DOB	Age	Today's Date	Signature
_____	_____	_____	_____	_____

Your child *cannot* receive the Flu Vaccine if she/he:

1. Has had a serious reaction to a previous dose of flu vaccination or any components. **YES**____ **NO**__
2. Have a history of Guillain-Barre Syndrome (GBS). **YES**____ **NO**____
3. Has a fever of 102 or higher at this time. **YES**____ **NO**____

_____ 0.5ml Flu Injection _____ FluMIST

TO BE COMPLETED BY NURSING STAFF:

Nurse _____ Injection Site _____

FluMist Eligibility Form

1. Do any of the following apply to the person being vaccinated with FluMist?
(If the answer is YES, the person to be vaccinated cannot receive FluMist)

YES ☐ NO ☐

- Is under 2 years of age
- Has an allergy to gentamicin, gelatin or arginine
- Has had life-threatening reaction to influenza vaccine in the past
- Is between 2 years and 17 years of age and currently receiving aspirin or medicines containing aspirin

2. Do any of the following apply to the person being vaccinated?
(If the answer is YES, please determine whether the person to be vaccinated can receive FluMist)

YES ☐ NO ☐

- Has asthma or is 2 years to 5 years of age and has wheezed (asthma equivalent) in the last 12 months
- Has experienced Guillain-Barre syndrome within 6 weeks following any prior influenza vaccination
- Has a weakened immune system or has health problems such as heart, lung, liver, kidney or metabolic disease (e.g., diabetes), or blood disorders

3. Does the person to be vaccinated live with a person who has a severely weakened immune system or expect to have close contact with a person whose immune system is compromised?
(If the answer is YES, please determine whether the person to be vaccinated can receive FluMist)
Vaccine recipients or their parents/guardians should be informed by the healthcare provider that FluMist is an attenuated live virus and has the potential for transmission to immunocompromised household contacts. According to CDC/ACIP, individuals with immunocompromised persons – including those with immunosuppression due to chemotherapy – may receive FluMist.

YES ☐ NO ☐

4. Has this person received any other immunizations in the last 30 days?
(If the answer is YES, please consult with the nurse to verify eligibility.)

YES ☐ NO ☐

COVID-19 Vaccination Screening and Consent Form

Patients Name: _____ **DOB:**_____ **Age:**_____

Signature of parent/patient/guardian:_____

PLEASE CIRCLE YES OR NO FOR THE FOLLOWING QUESTIONS:

1. Have you experienced any type of immediate allergic reaction, defined as hypersensitivity related signs or symptoms consistent with anaphylaxis, urticaria, angioedema, respiratory distress (wheezing, stridor) that occurs within 4 hours, to your previous dose of mRNA COVID -19 vaccine OR to any of its components, specifically polyethylene glycol or polysorbate?
   YES NO
2. Do you have a history of an immediate allergic reaction (defined as hypersensitivity-related signs or symptoms consistent with anaphylaxis, urticaria, angioedema, respiratory distress (wheezing, stridor) that occurs within 4 hours) to other vaccines or injectable therapies?
   YES NO
3. Do you have a history of anaphylaxis/severe allergic reaction for any reason?
   YES NO
4. Have you received convalescent plasma or monoclonal antibodies as part of COVID-19 treatment in the past 3 months? **YES NO**

_____	_____	_____
Date Given	**Nurse Initials**	**Site Given**