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®.**

Patient Name: _____ **Date of Birth:** _____/_____/_____

Precautions and Contraindications: Please mark YES or NO for each question.	**Yes**	**No**
1. Is your child sick today?	☐	☐
2. Has your child ever had a severe allergy to eggs or to a component of the influenza vaccine?	☐	☐
3. Has your child ever had a serious reaction to intranasal influenza vaccine (FluMist) in the past?		
4. Is the person to be vaccinated younger than age 2 years or older than 49 years?	☐	☐
5. 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?	☐	☐
6. I 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?	☐	☐
7. 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?	☐	☐
8. Is the person to be vaccinated receiving influeza antiviral medications?	☐	☐
9. Is your child receiving aspirin therapy or aspirin-containing therapy?	☐	☐
10. Is your child pregnant or could she become pregnant in the next month?	☐	☐
11. Has your child ever had Guillain-Barre syndrome? ?	☐	☐
12. 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)?	☐	☐
13. 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.

I have read the above information about FluMist® and have truthfully answered all 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.

_____

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

Office Use Only: I have reviewed the above information.

_____ _____ _____

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

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