



Influenza Vaccine Consent Form 2011-12

Last Name _____ First Name _____ Middle Initial _____

Mailing Address _____ City _____ State _____ Zip code _____

Birth date _____ Age _____ circle one: Male / Female Phone No. _____

The following question will help us to determine if your child can receive the Inactivated Influenza Vaccine (flu shot) or the Intranasal Influenza Vaccine (FluMist). Please make **YES** or **NO** for each question.

- | | | |
|--|---------------------------------|--------------------------------|
| 1. Have you or your child ever had a serious allergic reaction to eggs or to a component of any flu vaccine? | YES
<input type="checkbox"/> | NO
<input type="checkbox"/> |
| 2. Have you or your child ever had a serious reaction to a previous dose of flu vaccine? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you or child ever had Guillain-Barre Syndrome (GBS, i.e., progressive ascending paralysis)? | <input type="checkbox"/> | <input type="checkbox"/> |

If you answered Yes or left blank any question from #1 through #3, STOP; your child or yourself should NOT receive any flu vaccine. If you answered NO to all the three questions, please continue.

- | | | |
|--|--------------------------|--------------------------|
| 4. Is your child less than 2 years of age? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you or your child have a long-term health problem such as heart disease, kidney disease, lung disease (e.g., asthma, wheezing in last 12 months), metabolic disease (e.g., diabetes), or blood disorders (e.g., anemia)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you or your child have a weakened immune system caused by cancer, cancer treatment (e.g., steroids) that weaken the immune system? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you or your child live with or have close contact with anyone with a severely weakened immune system requiring care in a protected environment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Are you or your child receiving aspirin or other salicylate medication? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Are you or your child taking any prescription medicines to prevent or treat flu? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Will you or your child be receiving a MMR (measles/mumps/rubella) & /or varicella (chickenpox) vaccination within the last 4 weeks? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Are you pregnant?
How many weeks? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

If you answered YES or left blank any question from #4 through #10, your child or yourself should NOT receive the FluMist, but he/she can receive the flu shot.

CONSENT FOR CHILD'S VACCINATION: I have read the 2011-12 Vaccine Information Statements for the flu shot and the FluMist, understand the risks and benefits, and give consent to Dr. K's Kids Pediatrics its authorized staff for my child named at the top of this form to receive:

- Flu shot
 FluMist (nasal spray)

PLEASE CHECK ONLY ONE BOX!

Signature/Parent or Legal Guardian _____ Date: ____/____/____

2nd DOSE ONLY – CONSENT FOR CHILDREN 8 YEARS AND YOUNGER ONLY FOR 2ND DOSE OF VACCINE

My child is age 8 years or younger and has previously received less than 2 doses of flu vaccine. I have read the 2011-12 Vaccine Information Statements for the flu shot and the FluMist, understand the risks and benefits, and give consent to Dr. K's Kids Pediatrics and its authorized staff for my child named at the top of this form to receive a **second dose** of:

- Flu shot
 FluMist (nasal spray)

PLEASE CHECK ONLY ONE BOX!

Signature/Parent or Legal Guardian _____ Date: ____/____/____

Vaccine	Date Dose Administered	Route	Vaccine Manufacturer	Lot Number	Expiration Date	VIS Pub. Date	Name, Title of Vaccine Administrator
1 st dose	/ /					7/26/2011	Erika Mora, CMA or Maria Rocha, CMA
2 nd dose	/ /						