

FLUMIST™ CONSENT FORM

School			Room Number		
Student's Last Name	First	MI	Date of Birth	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Address					
City		State		ZIP	
Please choose one of the following: <input type="checkbox"/> No Insurance <input type="checkbox"/> Medicaid / Hoosier Healthwise <input type="checkbox"/> Private Insurance				Race	
Name of Responsible Adult			Phone Number		

Your child cannot receive FluMist™ if you answer “yes” to any of the following questions. Please see your private physician to determine which flu vaccination is appropriate for your child.

Precautions and Contraindications: <i>Please check Yes or No for each question.</i>	Yes	No
1. Has your child or will your child receive the MMR, H1N1 Mist, Seasonal FluMist™ or Varicella (chickenpox) vaccine within 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>
2. Has your child had a severe allergic reaction (hives or trouble breathing) to any part of the vaccine (eggs, egg proteins, gentamicin, gelatin, or arginine)?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has your child ever had a life-threatening reaction to FLU vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>
4. Is your child currently receiving aspirin or aspirin-containing (salicylate) treatment (not Tylenol or ibuprofen)? ...	<input type="checkbox"/>	<input type="checkbox"/>
5. Does your child have asthma, recurrent wheezing, or active wheezing?	<input type="checkbox"/>	<input type="checkbox"/>
6. Has your child ever had Guillain-Barré syndrome?	<input type="checkbox"/>	<input type="checkbox"/>
7. Does your child have a muscle or nerve disorder (such as seizures or cerebral palsy) that can lead to breathing or swallowing problems?	<input type="checkbox"/>	<input type="checkbox"/>
8. Does your child have any diseases (for example, cancer, lupus, or HIV/AIDS) or take a medication (for example, steroids or chemotherapy) that lowers the body's resistance to infection?	<input type="checkbox"/>	<input type="checkbox"/>
9. Is your child pregnant or nursing?	<input type="checkbox"/>	<input type="checkbox"/>
10. Does your child have close contact with anyone who has a weakened immune system (for example, an individual who has had a bone marrow transplant and currently hospitalized in isolation)?	<input type="checkbox"/>	<input type="checkbox"/>
11. Does your child have a health concern such as chronic heart disease, lung disease, sickle cell disease (not trait), kidney or liver disease, metabolic disease (such as diabetes), anemia, thalassemia or any other blood disorders?	<input type="checkbox"/>	<input type="checkbox"/>

CONSENT FOR SERVICES

I have reviewed the Vaccine Information Sheet. I have read the adverse reactions associated with the seasonal FluMist™ Vaccine. I have had the chance to ask questions and to fully understand the benefits and risks of seasonal FluMist™ Vaccine. I request that seasonal FluMist™ Vaccine be given to the student named above.

LEGAL GUARDIAN SIGNATURE: _____ Date: _____

Printed Name: _____

FOR CHILDREN LESS THAN NINE (9) YEARS OF AGE

I understand that since my child is less than nine (9) years of age, they may require a **SECOND** dose of seasonal FluMist™ Vaccine in 4–6 weeks if they have not had two doses of a seasonal influenza vaccine in the past. I consent for my child to receive the second dose of vaccine. I understand that I will be informed of the need for a second dose before it is given and that I may elect to not have my child get the second dose of seasonal FluMist™ Vaccine at that time.

LEGAL GUARDIAN SIGNATURE: _____ Date: _____

Printed Name: _____