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Influenza Vaccine Administration Record and Informed Consent

Patient Name: _____ Date of Birth: _____

I want to receive the following immunization: □ Flu shot □ FluMist (nasal) Available for ages 2+

The following questions will help us determine your child's eligibility to be vaccinated today.

***For flu shot**: Please answer questions under All Vaccines* ***For FluMist:** Please answer ALL questions.*

All vaccines						
If under age 9, have you received a flu vaccine before?		Yes		No		Don't know
Have you had a fever greater than 101° F within the last 24 hours?		Yes		No		Don't know
History of a life-threatening reaction to the influenza vaccine in the past?		Yes		No		Don't know
Have a severe (anaphylactic) allergy to eggs, gelatin, latex, or gentamicin sulfate? If yes, please list: _____		Yes		No		Don't know
History of Guillain-Barre syndrome (GBS)?		Yes		No		Don't know
FluMist						
Receiving aspirin therapy or aspirin-containing therapy?		Yes		No		Don't know
Have cancer, leukemia, lymphoma, HIV/AIDS, transplant, functional or anatomic asplenia, CSF leak, cochlear implant, or any other immunosuppressed illness?		Yes		No		Don't know
Currently on home infusions, weekly injections, high dose methotrexate, azathioprine or 6-mercaptopurine, anticancer drugs, or radiation treatments?		Yes		No		Don't know
Currently taking high-dose steroid therapy for longer than 2 weeks?		Yes		No		Don't know
Taken any influenza antiviral medications within the previous 48 hours?		Yes		No		Don't know
History of wheezing or asthma with inhaler use in the past 12 months?		Yes		No		Don't know
Have diabetes or other type of metabolic disease or disease of heart, lung, kidneys, liver, nerves, or blood?		Yes		No		Don't know
Received any live vaccines (MMR, varicella (chickenpox), zoster, or yellow fever) in the past 4 weeks?		Yes		No		Don't know
Ever had a seizure disorder for which you are on seizure medications, a brain disorder, or nervous system problems?		Yes		No		Don't know
Expect to have close contact with a severely immunocompromised person within the next 7 days?		Yes		No		Don't know
Females: Any possibility that you are pregnant?		Yes		No		Don't know

I have read or have had explained to me the Vaccine Information Statement (dated: 08/07/2015). I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risk of influenza vaccine and ask that the vaccine be given to the person named above for whom I am authorized to make this request (parent or guardian). I release Leawood Pediatrics from all liability related to administration of this vaccine.

Signature _____ Relationship _____ Date _____

----------FOR CLINIC USE ONLY----------

Date Booster Required (if applicable): _____

Vaccine	**Route**	**Date Dose Administered**	**Vaccine Manufacturer**	**Lot Number**
Influenza	IM Intranasal	/ /		
Name and Title of Vaccine Administrator				