

## 2011-2012 Influenza Vaccine Consent Form

I was given my own copy of either of the Influenza Vaccine Information Sheets: LIVE, INTRANASAL INFLUENZA VACCINE (dated 07/26/11) and/or the INACTIVATED INFLUENZA VACCINE (dated 07/26/11).

I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the vaccine and request that the vaccine be given to me or to the person named below for whom I am authorized to make this request.

Patient Name \_\_\_\_\_  
Last Name First Name MI

Patient Birth Date \_\_\_\_\_

Patient Address \_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City State Zip

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**Parents, please answer the following questions to determine which vaccine your child qualifies for.**

### **Influenza Vaccine** –

Is your child younger than 6 months of age?	Yes [ ]	No [ ]
Is your child on a chronic aspirin therapy?	Yes [ ]	No [ ]
Does your child have muscle or nerve disorder or a weakened immune system?	Yes [ ]	No [ ]
Does your child have an egg allergy or had an allergic reaction to the flu vaccine in the past?	Yes [ ]	No [ ]

*If you have answered yes to any of the above questions, your child is not eligible for the Influenza Vaccine and options should be discussed with a physician.*

### **Live Intranasal Vaccine** -

Is your child less than 2 years old on the day of vaccination?	Yes [ ]	No [ ]
Is your daughter pregnant?	Yes [ ]	No [ ]
Does your child have any of the following chronic medical conditions: Heart Disease, Kidney Disease, Lung Disease, Metabolic Disease (such as diabetes), Asthma, Liver Disease, Anemia (or other blood disorders), or a Weakened Immune System?	Yes [ ]	No [ ]
Does your child have close contact with someone who has a Weakened Immune System?	Yes [ ]	No [ ]

*If you have answered yes to any of the above questions, your child is not eligible for the Intranasal Influenza Vaccine and options should receive the Injectable Influenza Vaccine.*

Clinic Use Only

Please circle one	Influenza Vaccine	Flumist Intranasal Vaccine
Date of Vaccination	_____	
Name of Vaccine Administrator	_____	
Manufacture	_____	Lot # _____