



Influenza Vaccine Consent Form

A. There are 2 types of vaccine available, the injectable flu vaccine and the intranasal flu vaccine (FOR THE INTRANASAL, MUST BE OVER 2 YEARS OLD AND MEET CRITERION IN SECTION C). All patients must fill out Section B and then patients who are choosing the intranasal vaccine, must fill out Section C. If you answer YES to any questions, you must discuss the vaccine with a physician.

B. FOR PATIENTS RECEIVING EITHER TYPE OF INFLUENZA VACCINE (INJECTABLE OR INTRANASAL):

<u>YES</u>	<u>NO</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Is the patient severely allergic to eggs or egg products?
<input type="checkbox"/>	<input type="checkbox"/>	Has the patient ever had Guillain-Barré Syndrome?
<input type="checkbox"/>	<input type="checkbox"/>	Has the patient ever had an anaphylactic allergic reaction to the influenza vaccine?
<input type="checkbox"/>	<input type="checkbox"/>	Does the patient have a high fever currently?

C. FOR PATIENTS RECEIVING THE LIVE INTRANASAL INFLUENZA VACCINE (FLUMIST®) ONLY:

<u>YES</u>	<u>NO</u>	CHILD MUST BE OVER 2 YEARS OF AGE TO RECEIVE THIS VACCINE!
<input type="checkbox"/>	<input type="checkbox"/>	Is the patient under 5 years of age and had recurrent wheezing or a diagnosis of asthma in the past?
<input type="checkbox"/>	<input type="checkbox"/>	Does the patient have a chronic disease such as heart or lung disease, asthma or reactive airways disease, diabetes or kidney failure?
<input type="checkbox"/>	<input type="checkbox"/>	Does the patient have an illness that weakens the immune system or takes any medication that can weaken the immune system (like chronic steroids)?
<input type="checkbox"/>	<input type="checkbox"/>	Does the patient currently have a very congested nose?
<input type="checkbox"/>	<input type="checkbox"/>	Is the patient pregnant?

If you answered a "YES" in either section, please discuss with a doctor before receiving the vaccine.

D. FOR ALL PATIENTS RECEIVING SEASONAL VACCINE (CHOOSE ONE OPTION):

I am choosing to have the inactivated influenza vaccine shot for the patient noted below.

Possible reactions to influenza vaccine shot:

Mild: Soreness or redness at the site of injection, fever, body aches.

Severe: Allergic reactions with fever, difficulty breathing, hives, rapid heart beat. Guillain-Barré Syndrome which is progressive muscle weakness and paralysis which may occur a week after the vaccine (1-2 cases per million persons vaccinated).

I am choosing to have the live intranasal influenza vaccine for the patient noted below.

Possible reactions to live intranasal influenza vaccine:

Mild: Runny nose, cough, body aches, fever, stomachaches, wheezing, fatigue, sore throat, headache.

Severe: Allergic reactions with fever, difficulty breathing, hives, rapid heart beat.

I have read the Influenza Vaccine Information Sheet for the vaccine my child will receive and understand the risks and benefits of the vaccination. I hereby consent for my child to receive the influenza vaccine.

Signed: _____ Date: _____

(Print) Patient Name: _____ Date of Birth: _____