ADULTS

2012-13 Live Flu Nasal Spray Consent Form

NASAL SPRAY CONSENT & SCREENING FORM

Nasal Spray is for people age 2 – 49 years ONLY

NAME: _____AGE: _____Male: _ Female: _

ADDRESS: _____ PHONE #: _____

CITY: _____STATE: ___ ZIP: _____DoB: _____

1. Have you received a vaccine within the past 30 days or will you in the next 30 days? ------Yes ___ No ___
   If yes, please list name of vaccine(s):_____
2. Have you received a flu or flu mist vaccination before? ----------Yes ___ No ___
3. Are you sick today? ----------Yes ___ No ___
4. Are you allergic to any part of the vaccine (eggs, egg proteins, gentamicin, gelatin, arginine or MSG)? ----------Yes ___ No ___
5. Have you ever had a life-threatening reaction to an influenza vaccine? ----------Yes ___ No ___
6. If you are age 2-17, are you currently take aspirin or aspirin-containing therapy? ----------Yes ___ No ___
7. Do you have asthma, recurrent wheezing (only relevant to children under 5 years of age), or active wheezing? Have you used an inhaler in the last 12 months?------Yes ___ No ___
8. Have you ever had Guillain-Barré syndrome? Or active neurological disorders? ----------Yes ___ No ___
9. Do you 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? ----------Yes ___ No ___
10. Are you pregnant or nursing? ---------- Yes ___ No ___
11. Do you have any of the following long-term health problems? (CIRCLE) ---------- Yes ___ No ___
    heart disease kidney disease metabolic diseases (for example, diabetes)
    liver disease lung disease anemia or other blood disorder other_____
12. Please let us know if you have close contact with anyone who has a weakened immune system (for example, an individual who has had a bone marrow transplant and is in a negative pressure hospital room). Please describe:

_____

FLU MIST VACCINE CONSENT

I have been given the 2012-13 CDC Flu Mist Vaccine Information Statement. I have had the opportunity to ask questions that have been answered to my satisfaction. I believe I understand the benefits and risks of the intra nasal flu vaccine and I request and consent that it be given to me or to the person named of whom I am parent, guardian or authorized person.

Signature:X_____ Date: _____

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Flu Mist Vaccine Lot #: _____ Exp Date: _____ Dose 1:____ 0.2 ml intranasal

Flu Mist Vaccine Lot #: _____ Exp Date: _____ Dose 2:____ 0.2 ml intranasal

Screened/Administered by: _____