

2010-2011 Seasonal FluMist Consent Form

PLEASE COMPLETE THE INFORMATION BELOW (Unreadable forms will NOT be accepted)

Name of School	Teacher/Grade		
Full Legal Name of Child	DOB	Age	Sex
Address	City Zip Code		
Parent/Guardian Name	Relationship	Physician	Phone #
Phone #	Emergency #	Social Security #	
Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Multi - Racial <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Not Known			
<input type="checkbox"/> YES, I want my child to participate (Please complete the form) <input type="checkbox"/> No, I do not want my child to participate (Not necessary to complete form but please turn it in)			

Student Label

Part 1: General Information and H1N1/Flu History (Check the one that best describes your child)

1. Did your child receive 2 H1N1 vaccines last year? Yes No Do not know
 2. Has your child received 2 or more seasonal flu vaccines before? Yes No Do not know
 3. Has your child received any type of vaccination within the past month? Yes No
- If yes, write vaccine type and date received: _____

Part 2: Precautions and Contraindications: CHECK Yes or No for each answer

(If you answer YES to any of the questions below, your child cannot receive the FluMist at school)

- | | | |
|--------------------------|--------------------------|--|
| Yes | No | <p>1. Does any of the following apply to your child?</p> <ul style="list-style-type: none"> * Allergic reaction to eggs or egg products * Life threatening reactions to flu vaccine in the past * Currently receiving aspirin or aspirin-containing therapy * Currently has active asthma (taking asthma medication) * Had Guillain-Barre syndrome (very rare) * Have long term health problems with weakened immune system, heart disease, liver disease, lung disease (including cystic fibrosis), kidney disease, metabolic disorders (e.g. diabetes) or blood disorders (e.g. sickle cell or thalassemia) * Has HIV/AIDS, cancer or has received an organ transplant |
| <input type="checkbox"/> | <input type="checkbox"/> | |
- | | | |
|--------------------------|--------------------------|--|
| Yes | No | <p>2. Will your child have close contact with a person whose immune system is severely compromised?
(For example the person must be in a protective environment or a negative-pressure hospital room)</p> |
| <input type="checkbox"/> | <input type="checkbox"/> | |
- | | | |
|--------------------------|--------------------------|--|
| Yes | No | <p>3. Does your child have any other chronic health problems that you are aware of?</p> |
| <input type="checkbox"/> | <input type="checkbox"/> | |
- * If yes, what is the health problem? _____

I have been given a copy of the 2010-2011 CDC Vaccine Information Sheet (VIS) for the live attenuated intranasal seasonal influenza vaccine (see attached). I have read the document and have no further questions at this time. I understand the risks and the benefits of the vaccine. I request and voluntarily consent that the FluMist be given to _____ of whom I am the legal parent or guardian, and for a second dose to be given in one month as recommended. I acknowledge that no guarantees have been made concerning the vaccine's successes. I understand that the side effects and warnings of the vaccine. I also allow the consent form to be given to the Escambia County Health Department for data entry and storage according to the Florida Department of Health for storage and retention policy.

Printed Name of the Parent/Guardian

Signature of the Parent/Guardian

Date

FOR OFFICIAL USE ONLY

Dose # 1

Lot# _____	Exp Date: _____	Manufacturer: Medimune (MED)
Vaccine: FluMist	IN (Intranasal) 0.2ml	VIS Date: ____/____/____
Date Given: _____	Signature/Title: _____	

Dose # 2

Lot# _____	Exp Date: _____	Manufacturer: Medimune (MED)
Vaccine: FluMist	IN (Intranasal) 0.2ml	VIS Date: ____/____/____
Date Given: _____	Signature/Title: _____	