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Vaccination Consent Form

For FluMist™, Influenza Virus Vaccine, Intranasal

Instructions: Before you can receive FluMist™, you must read this information sheet, answer the questions, and ask your health care professional administering the vaccine to review them.

FluMist should only be administered to children and adolescents 5-17 years old and adults 18-49 years old who are healthy. Certain people must not receive FluMist. **You must answer each question below, and have the answers reviewed by the health care professional to ensure you are eligible to receive FluMist.** The health care professional will keep this questionnaire, and any information collected in a confidential manner.

How old are you? _____

No.	Observation	Yes	No
1.	Are you allergic to eggs?		
2.	Do you have any problems with your immune system?		
3.	Do you have AIDS, HIV, cancer, or have you received an organ transplant?		
4.	Did your doctor ever tell you that you had asthma or reactive airway disease?		
5.	Do you have any disease of the lungs, including chronic bronchitis, emphysema, or cystic fibrosis?		
6.	Did you ever have Guillain-Barre syndrome or active neurological disease?		
7.	Do you have kidney disease?		
8.	Are you pregnant or nursing?		
9.	Do you have heart disease (angina, congestive heart failure) or have you ever had a heart attack or stroke?		
10.	Do you have a blood disease like sickle cell disease or thalassemia?		
11.	Do you currently have a cold or other respiratory illness or a fever?		
12.	Have you had any vaccines within the last month or do you plan to receive any within the next month?		
13.	Are you taking any prescription medicine to prevent or treat the flu?		
14.	Does anyone living with you have a compromised immune system?		
15.	Do you have diabetes or any other metabolic disease?		

I have read the above information about FluMist and have truthfully answered all of the questions on this form. I have also received a copy if the Vaccine Information Statement for FluMist. I have had a chance to ask questions and fully understand the benefits and risks of vaccination with FluMist. My signature below indicates my permission for FluMist to be given to me.

 Printed Name of Person to Receive Vaccine

FluMist given on: (Date) _____ (Time) _____ (Lot number) _____

 Signature of Person to Receive Vaccination

 Signature of HCP/ Date

Where to Report Adverse Reactions (Side Effects):

If you have a reaction after getting FluMist, you should contact your pharmacists or physician right away. You are encouraged to report any reaction from the vaccine to the FDA (the Food and Drug Administration) using the Vaccine Adverse Events Report (VAERS) form available at <https://secure.vaers.org>. The VAERS reporting form and instructions for submitting it can be obtained by calling toll-free 1-800-822-7967 or by toll-free fax at 1-877-721-0366