

## Vaccination Consent Form for FluMist® (Influenza Virus Vaccine Live, Intranasal)

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 your answers. FluMist should only be administered to children and adolescents 5-17 years old and adults 18-49 years old who are healthy and not pregnant. 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. There are risks associated with all vaccines, including FluMist. Like any vaccine, FluMist does not protect 100% of individuals vaccinated. In studies of people between the ages of 5 and 49, side effects were generally mild and temporary. Runny nose was the most common. Other common side effects included various cold-like symptoms, such as headache, cough, sore throat, tiredness/weakness, irritability, and muscle aches.

How old are you? \_\_\_\_\_

**Precautions and Contraindications:** Please mark YES or NO for each question.

|  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| 1. Are you allergic to eggs?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Has a doctor ever told you that you have an immune system disorder?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you have AIDS, HIV, cancer or have you received an organ transplant?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have a history of asthma or reactive airway disease?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any disease of the lungs, including chronic bronchitis, emphysema, or cystic fibrosis?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Did you ever have Guillain-Barre syndrome?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have kidney disease?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Are you pregnant or nursing?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you have heart disease (angina, congestive heart failure) or have you ever had a heart attack or stroke?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you have a blood disease like sickle cell disease or thalassemia?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you currently have a respiratory illness or a fever?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you received any vaccines within the last month or do you plan to receive any within the next month?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Are you taking any prescription medicines to prevent or treat influenza?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. If you are under 18 years of age, are you currently receiving aspirin or aspirin-containing therapy?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Do you have diabetes or other metabolic disease?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Does anyone living with you have a compromised immune system?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Are you in close contact with severely immunocompromised individuals requiring a protective environment (such as bone marrow transplant recipients)? | <input type="checkbox"/> | <input type="checkbox"/> |

**If you answered yes to any of the above, your physician will need to determine if FluMist is right for you.**

**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 of 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 administered to me.**

\_\_\_\_\_  
Printed Name of Person to Receive Vaccine

FluMist give on: (Date) \_\_\_\_\_ (Time) \_\_\_\_\_ Lot Number \_\_\_\_\_

\_\_\_\_\_  
Signature of Person to Receive Vaccine      Date

\_\_\_\_\_  
Signature of HCP      Date

**Where to Report Adverse Reactions (Side Effects):**

If you have a reaction after getting FluMist, you should contact your physician or pharmacist 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 Reporting System (VAERS) form available at <https://secure.vaers.org/VaersDataEntryintro.htm>. 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.