



HARFORD COUNTY HEALTH DEPARTMENT 2009-2010 SCHOOL INFLUENZA NASAL SPRAY (FLUMIST®) VACCINE CONSENT FORM

Student last name:	Student First Name:	Student Date of Birth:	Age on vaccination day:
School:	Student's Teacher:		Student's Grade:

The following questions will help us determine if your child may receive the Influenza Nasal Spray (FluMist®) vaccine. Please mark Yes or No for each question.

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Does your child have a long-term health problem such as heart disease, kidney disease, lung disease, liver disease, diabetes, or a blood disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Has your child ever had any form of asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Has your child ever had a serious reaction, such as difficulty breathing, to eggs or a flu vaccine? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. On a regular basis or frequently, does your child take medicine that has aspirin in it? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Does your child have a very weak immune system caused by cancer, cancer treatment, HIV, an organ transplant, or any other drugs that weakens the immune system? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Has a doctor ever said your child has Guillain-Barré syndrome (a serious nervous system disorder)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Does your child live with anyone who has a severe immune system condition that requires care in a protected environment, like an organ transplant, cancer treatment or AIDS? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Has your child received a vaccine for measles, mumps, rubella, or chickenpox in the last month? | <input type="checkbox"/> | <input type="checkbox"/> |

► Note: It is acceptable for your child to get influenza nasal spray vaccine if a household member is pregnant or has chronic medical problems OTHER than severe immune problems. If your child has any of the above conditions, they may not receive the influenza nasal spray vaccine. **On the day of vaccination your child should not receive the influenza nasal-spray vaccine if he/she has a bad cold or is taking medicine for the flu (specifically amantadine, rimantidine or Tamiflu®)**

CONSENT FOR CHILD'S VACCINATION:

I have read the information statement entitled "Live, Intranasal Influenza Vaccine 2009-2010" explaining the risks and side effects of the influenza nasal spray vaccine. I understand the risks and benefits, and give consent to the Harford County Health Department and its authorized staff for my child, named at the top of this form, to receive the influenza nasal spray vaccine. I also consent to having information regarding my child's influenza vaccination shared with my child's doctor.

Signature of Parent/Guardian

Printed name of Parent/Guardian

Date

FOR HEALTH DEPARTMENT USE ONLY:

Reason vaccine NOT Given:

- Student had temp ≥ 100.5
- Student refused vaccine
- Student absent
- Other _____

Place Flu Vaccine Label Here