Influenza Vaccine Consent Form - FluMist

2025-2026 MASS CLINIIC – FORM A

PLEASE COMPLETE THE INFORMATION BELOW (PLEASE PRINT)

Full, Legal Name of Student *(First Name, Middle Name, Last Name)*		**Name of School**	
Parent/Guardian Name *(First Name, Middle Name, Last Name)*	**Relationship to student**	**Grade**	
Street Address	**Email Address**	**Birth Date** *(month/date/year)*	**Age** **Sex**
City	**Zip Code**	**Phone #**	

Demographic Information: *(Circle one)* **White** **American Indian/Native American** **Black** **Asian** **Hispanic** **Other**

HEALTH QUESTIONS:

(If you answer YES to any questions, your child CANNOT receive FluMIst, but please contact your healthcare provider or call the Health Department to speak with a nurse at 608-326-0229 to discuss other flu vaccine options.

YES **NO**

☐ ☐ **1. Do any of the following apply to your child?**

- Allergy to gelatin, chicken eggs or egg products
- Life threatening reaction(s) to flu vaccine in the past
- Currently receiving aspirin or aspirin-containing therapy
- Currently have active asthma (regularly taking asthma medication)
- Had Guillain-Barre syndrome (very rare)
- Non-functioning spleen or no spleen
- Cerebrospinal fluid (CSF) leak or cochlear implants
- Younger than 2 years or older than 49
- Is pregnant or nursing/breastfeeding
- Has HIV/AIDS or cancer or has received an organ transplant
- Has long-term health problems with weakened immune system, heart disease, lung disease (e.g. Cystic fibrosis), liver disease, kidney disease, or metabolic disorders (e.g. diabetes) or blood disorders (e.g. sickle disease or thalassemia) or taking medication that weakens the immune system (e.g. steroids, anti-cancer medication)

☐ ☐ **2. Has a weakened immune system or will have close contact with a person with a severely weakened immune system?**
(e.g. protective sterile hospital environment for bone marrow transplant)

☐ ☐ **3. Has your child received one of the following vaccines <u>in the past 30 days</u>: MMR, MMRV, and/or Chicken Pox vaccine (VZV)?**

☐ **YES**, I have read and answered the questions on this form accurately and understand that incorrect information could cause serious risks to myself or the person named above. I have received and read the Vaccine Information Sheets provided and have had the opportunity to ask question that were answered to my satisfaction and do wish to receive the flu vaccination fully understanding the risks and benefits. I understand this information will be entered into the WI Immunization Registry for Public Health purposes. I release CCHHS, employees, and agents harmless from any and all liability arising in relation to this consent.

My signature below indicates my permission for the FluMist vaccine to be given to me, or the person named above, and I am the parent or legal authority with authority to consent to vaccination.

_____ _____
Signature of Parent/Guardian **Date**

AREA FOR OFFICIAL USE ONLY FOR ADMINISTRATION

Are you experiencing fever or upper respiratory infection? ☐ **YES** ☐ **NO**

Medimmune (MED) **FluMist Intranasal (NAS) 0.2ml** **VIS: 08/6/2021**	Vaccine Lot # & Expiration Date Label	**Nurse/clinic Notes**

Notes:

Route: **Intranasal**	**Site of Injection:**	**RN Signature:** **Lisa Kinnecker, RN** **Tricia Koeller, RN**	**Date Given:**

WIR _____