Influenza Vaccine Consent Form - FluMist

2024-2025 MASS CLINIC - FORM B

PLEASE COMPLETE THE INFORMATION BELOW (PLEASE PRINT)

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

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

Has your child received any vaccine (not just flu) within the past 30 days? **Vaccine** _____ **Date given** _____

MMR, MMRV, and/or Chicken pox vaccine (Varicella) **Month Day Year**

HEALTH QUESTIONS:

1. Check the following that apply to your child?

- ☐ Is younger than 2 years or older than 49 years of age
- ☐ Is pregnant. Live, attenuated influenza vaccine is not recommended for pregnant people
- ☐ Has had an allergic reaction after a previous dose of influenza vaccine, or has any severe, life-threatening allergies
- ☐ Is a child or adolescent 2 through 17 years of age who is receiving aspirin or aspirin- or salicylate-containing products
- ☐ Has a weakened immune system
- ☐ Is a child 2 through 4 years old who has asthma or a history of wheezing in the past 12 months
- ☐ Is 5 years or older and has asthma
- ☐ Has taken influenza antiviral medication in the last 3 weeks
- ☐ Cares for severely immunocompromised people who require a protected environment
- ☐ Has other underlying medical conditions that can put people at higher risk of serious flu complications (such as lung disease, heart disease, kidney disease like diabetes, kidney or liver disorders, neurologic or neuromuscular or metabolic disorders)
- ☐ Does not have a spleen, or has a non-functioning spleen
- ☐ Has a cochlear implant
- ☐ Has a cerebrospinal fluid leak (a leak of the fluid that surrounds the brain to the nose, throat, ear, or some other location in the head)
- ☐ Has had Guillain-Barré Syndrome within 6 weeks after a previous dose of influenza vaccine

☐ **Will your child have close contact with a person with a severely weakened immune system?**

(For example, protective sterile hospital environment for bone marrow transplant) Avoid contact with those persons for 7 days after getting nasal spray vaccine.

(If you answer YES to any questions, your child cannot receive FluMist unless approved by your child's doctor)

IF YOU HAVE HEALTH QUESTIONS, PLEASE CONTACT YOUR CHILD'S HEALTH CARE PROVIDER
OR CALL THE CRAWFORD COUNTY HEALTH DEPARTMENT TO SPEAK WITH A NURSE AT; 608-326-0229

DO NOT RETURN this form if you do not want your child to receive the FluMist Vaccine at school.

☐ **YES, I Want To Protect My Child, Family And Community From Flu By Allowing My Child To Receive FluMist!**

I have received, read, and understand the CDC Vaccine Information Statement for the live attenuated intranasal flu vaccine (FluMist) and understand the risk and benefits of the FluMist vaccine. I give permission to the Crawford County Health Department to give my child the vaccine in my absence, and for data entry, billing and storage according to Wisconsin Department of Health policies, to assure optimal healthcare for my child.

_____ _____

Signature of Parent/Guardian Date

AREA FOR OFFICIAL USE ONLY FOR ADMINISTRATION

Are you experiencing any fever or upper respiratory infection? YES NO UNKNOWN

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 Kennicker, RN Tricia Koeller, RN	Date Given: