Patient name: _____ Date of birth: ____/____/____
(mo.) (day) (yr.)

Screening Questionnaire for Live Attenuated Intranasal Influenza Vaccination

For adult patients as well as parents of children to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child live attenuated intranasal influenza vaccine (FluMist) today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1. Is the person to be vaccinated sick today?	☐	☐	☐
2. Does the person to be vaccinated have an allergy to eggs or to a component of the influenza vaccine?	☐	☐	☐
3. Has the person to be vaccinated ever had a serious reaction to intranasal influenza vaccine (FluMist) in the past?	☐	☐	☐
4. Is the person to be vaccinated younger than age 2 years or older than age 49 years?	☐	☐	☐
5. Does the person to be vaccinated have a long-term health problem with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., diabetes), or anemia or another blood disorder?	☐	☐	☐
6. If the person to be vaccinated is a child age 2 through 4 years, in the past 12 months, has a healthcare provider ever told you that he or she had wheezing or asthma?	☐	☐	☐
7. Does the person to be vaccinated have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as high-dose steroids, or cancer treatment with radiation or drugs?	☐	☐	☐
8. Is the person to be vaccinated receiving antiviral medications?	☐	☐	☐
9. Is the child or teen to be vaccinated receiving aspirin therapy or aspirin-containing therapy?	☐	☐	☐
10. Is the person to be vaccinated pregnant or could she become pregnant within the next month?	☐	☐	☐
11. Has the person to be vaccinated ever had Guillain-Barré syndrome?	☐	☐	☐
12. Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g., an isolation room of a bone marrow transplant unit)?	☐	☐	☐
13. Has the person to be vaccinated received any other vaccinations in the past 4 weeks?	☐	☐	☐

Form completed by: _____ Date: _____

Form reviewed by: _____ Date: _____

Technical content reviewed by the Centers for Disease Control and Prevention, August 2011.

www.immunize.org/catg.d/p4067.pdf • Item #P4067 (8/11)

Patient's Full Name_____ Date of Birth_____

Consent to Receive Influenza Vaccine

I have read the Vaccine Administration Sheet (7/26/11) or have had the information explained to me. I have had a chance to ask questions and these questions have been answered to my satisfaction. I, hereby acknowledge that I have been informed of the possible risks, side effects and adverse reactions including, but not limited to, Guillain-Barré Syndrome, associated with the use of the influenza vaccine.

I understand that this season's vaccine is a combination of A/H1N1 (pandemic) influenza and two other influenza viruses-influenza A/H3N2 and influenza B.

I understand the benefits and risks of not taking the vaccine and ask that the vaccine be given to me.

I have completed the Screening Questionnaire for the **Injectable / Intranasal** (Please Circle) Influenza Vaccine and these special precautions do not apply to me.

I, therefore, release **Cabarrus Pediatrics** from any liability for possible complications.

I do agree to wait in the office for a period of 15 minutes after the injection in case I have any immediate side effects.

Patient's
(or Legal Representative's) Signature: _____Date: _____

Administered by: _____Date: _____

Manufacturer: _____Lot #: _____

Site: _____Dose:_____ Exp. Date: _____

Tolerated: _____Well, no reported problems

_____Not well, provider notified