Desert Shores
PEDIATRICS

FLUMIST LIVE NASAL VACCINE CONSENT FORM 2021-2022

Patient's Name: _____ DOB: _____

This year's seasonal intranasal quadrivalent influenza vaccine contains the following 4 strains: Influenza A (H1N1), Influenza A (H3N2), Influenza B (Victoria), and Influenza B (Yamagata)

Is your child under 2 years old?	YES	NO
Has your child ever had a serious reaction to the flu vaccine in the past?	YES	NO
Does your child have a severe egg allergy (more than a rash/hives)?	YES	NO
Has your child ever had Guillain-Barre (neuro disorder causing weakness/paralysis)?	YES	NO
Is your child taking aspirin or salicylate medications?	YES	NO
Is your child asthmatic?	YES	NO
Has your child wheezed in the last 12 months?	YES	NO
Is your child immunocompromised or live with someone who is?	YES	NO
Does your child have a serious chronic medical condition? (cardiac, pulmonary, renal, hepatic, neurologic or metabolic)	YES	NO
Does you child have sickle cell anemia, HIV, or a cochlear implant?	YES	NO
Does your child have a cerebrospinal (CSF) leak or active communication?	YES	NO
Does your child have anatomic or functional asplenia (is without a spleen)?	YES	NO
Is your child/teen pregnant or may be pregnant?	YES	NO
In the last 2 weeks, had your child had Tamiflu or other anti-flu medication?	YES	NO
Today, is your child moderately or severely ill with or without fever?	YES	NO
Today, is your child experiencing nasal congestion?	YES	NO

TURN OVER →

FLUMIST LIVE NASAL VACCINE CONSENT FORM 2020-2021

Patient's Name: _____ DOB: _____

ARIZONA DEPARTMENT OF HEALTH SERVICES

Parent or Guardian or Vaccine Recipient – **Please read and initial:**

Initials	
	Statement 1: I have read or have had explained to the me the information contained in the Vaccine Information Statements (VISs) about the following disease and vaccine: Influenza. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated on this form be given to me or the person names on this health record for who I am authorized to make this request.
	Statement 2: I agree to allow the health care provider giving vaccinations to release information about all vaccinations given to me, or to the person for whom I am authorized to consent to, to the Arizona State Immunization Information System (ASIIS), other health care providers and schools in order to avoid receiving unnecessary vaccinations and to provide information about what immunizations have been received. I understand that I am not required to agree to the release of this information in order to receive the vaccinations I request.

** If I do not wish this record to be included in ASIIS, I have the option of crossing out the above boxed statement and initialing it. I understand that by making this decision, I (or my child) will not have access to their immunization records (in ASIIS) in the future for schools, college attendance, future jobs/employment, military, etc.

I am authorized and consent to administration of the 2021-2022 influenza vaccine. I understand there is no guarantee that this vaccine will prevent my child from contracting influenza. Desert Shores Pediatrics will bill my insurance, if applicable. I understand that should my insurance deny payment for any reason, I am responsible for payment in full.

_____ _____

Signature of Parent/Legal Guardian **Date**