



FLUMIST LIVE NASAL VACCINE CONSENT FORM 2022-2023

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)

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|--|-----|----|
| 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? | YES | NO |
| Does your child live with someone who is immunocompromised? | YES | NO |
| Does your child have a serious chronic medical condition?
(heart, lungs (including asthma), kidney, liver, brain or metabolic (including diabetes)) | YES | NO |
| Does your 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 



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

Initials	
	<p><u>Statement 1:</u> I have read or have had explained to 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.</p>
	<p><u>Statement 2:</u> 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 (ASIS), 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.</p>

** If I do not wish this record to be included in ASIS, 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 ASIS) in the future for schools, college attendance, future jobs/employment, military, etc.

I am authorized and consent to administration of the 2022-2023 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