

All Saints/St. Matthews Health Promotion Centers  
Influenza Vaccine Consent Form 2009-2010

**This consent form is for the FluMist INHALED flu vaccine.**

Name (please print): \_\_\_\_\_

Parent name: (if minor) \_\_\_\_\_

**Read Vaccine Information Statement Before You Fill Out This Form.**

<http://www.cdc.gov/vaccines/pubs/vix/downloads/vis-flulive.pdf>

1. Are you allergic to eggs? [ ] Yes [ ] No
2. Have you ever had an adverse reaction to flu vaccine? [ ] Yes [ ] No
3. Are you ill or running a fever today? [ ] Yes [ ] No
4. Are you on long-term aspirin therapy? [ ] Yes [ ] No
5. Do you have a known or suspected immune deficiency? [ ] Yes [ ] No
6. Do you have a history of Guillain-Barre /syndrome. [ ] Yes [ ] No  
**(Guillain-Barre is a progressive paralysis syndrome.)**
7. Do you have a chronic condition such as: heart disease, lung disease, asthma, kidney disease, metabolic disease (i.e. Diabetes), anemia or other blood disorders? [ ] Yes [ ] No
8. Are you pregnant? [ ] Yes [ ] No [ ] NA

**Women in any stage of pregnancy CANNOT receive the FluMist vaccine.**

I have read the 2009-2010 Live, Intranasal Influenza Vaccine Information Sheet (VIS). I have had an opportunity to ask questions and understand the benefits and risks of influenza vaccination. As with all medical treatment, I understand that there is no guarantee that I will become immune or that I will not experience an adverse side effect from the vaccine. I request that it be given to me.

**Signature of Parent & Person Receiving Vaccine:**

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Parent: \_\_\_\_\_

Date: \_\_\_\_\_

**COST: \$20 payable to Mercy Medical Center. Due at time of immunization.**

Documentation of vaccination:

Manufacturer:

Lot Number:

Expiration date:

DATE: \_\_\_\_\_

ADMINISTERED BY: \_\_\_\_\_