

**FLU VACCINE CONSENT FORM – 2013-14**

Information collected on this form will be used to document permission for receipt of influenza vaccine. Record of this immunization may be shared through the Wisconsin Immunization Registry (WIR) with other health care providers directly involved with the vaccinated person's care.

**Information on person to receive vaccine**

Name (Last, First, Middle initial) Please Print		Gender Male _____ Female _____
Birthdate Month ____ Day ____ Year ____ Age ____	Parent/Guardian's Name	Telephone Number ( )
Address	City	County
	State	Zip Code
Okay to share immunization data with the Wisconsin Immunization Registry (WIR)? Yes _____ No _____		

**The 10 questions listed below are for screening purposes only and will help us determine if the person named above can receive the flu vaccine and which type (Injectable or Nasal). Please circle Yes or No**

1. Is the person to receive the vaccine have a history of eating eggs and developing difficulty breathing, throat swelling or hives?	YES	NO
2. Does the person to receive the vaccine have any other serious allergies? Please list _____	YES	NO
3. Has the person to receive the vaccine ever had a serious reaction or allergic response to past flu vaccinations?	YES	NO
4. Has the person to receive the vaccine ever had Guillian Barré syndrome (or other type of metabolic disease)?	YES	NO
5. Has the person to receive the vaccine been vaccinated with any vaccine within the past 4 weeks? (for example: nasal spray influenza, MMR, varicella, etc) Vaccine(s): _____ Date: _____	YES	NO
6. Within the past 12 months, has your healthcare provider ever told you that your child has wheezing or asthma?	YES	NO
7. Does the person to receive the vaccine have any of the following: diabetes (or other type of metabolic disease), disease of the heart, lung, kidneys, liver, nerves or blood?	YES	NO
8. Is the person (child or teen) to receive the vaccine on long-term aspirin or aspirin-containing therapy (for example, does your child take aspirin every day) or have a weakened immune system (for example, from HIV, cancer, or medications such as steroids)?	YES	NO
9. Is the person to receive the vaccine pregnant?	YES	No
10. Does the person to receive the vaccine have close contact with a person whose immune system is severely compromised and who must be in a protective isolation (such as in a hospital room with reverse air flow)?	YES	NO

**CONSENT FOR VACCINATION:** I have read, or have had explained to me, the Vaccine Information Statement for influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine be given the person named above for who I am authorized to make this request?

Signature X \_\_\_\_\_ Date \_\_\_\_\_

Form Reviewed By \_\_\_\_\_ Date \_\_\_\_\_

<b>FOR OFFICE USE</b>	<b>VIS Date 7-26-2013</b>
Route (Circle one)+ IM or Intranasal (IN)	Body Site (circle one) = RD, RV, LD, LV or IN
Manufacturer _____ Medimune _____	Lot No. _____ BH2124 _____
Signature and Title of Person Administering vaccine: _____ Date: _____	