

FLU VACCINE CONSENT FORM – 2014-15

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.

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 _____			
1. Is the person to be vaccinated sick today?		YES	NO
2. Does the person to be vaccinated have an allergy to eggs or to a component of the influenza vaccine?		YES	NO
3. Has the person to be vaccinated ever had a serious reaction to intranasal influenza vaccine?		YES	NO
4. Is the person to be vaccinated younger than age 2 years or older than age 49 years?		YES	NO
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?		YES	NO
6. If the person to be vaccinated is a child age 2 through 4 years, in the past 12 months, has a healthcare provider told you the child had wheezing or asthma?		YES	NO
7. Does the person to be vaccinated have cancer, leukemia, HIV/AIDS, or any other immune system problem; or, in the past 3 months, have they taken medications that weaken the immune system, such as cortisone, prednisone, other steroids, or anticancer drugs; or have they had radiation treatments?		YES	NO
8. Is the person to be vaccinated receiving antiviral medications?		YES	NO
9. Is the child or teen to be vaccinated receiving aspirin therapy or aspirin-containing therapy?		YES	NO
10. Is the person to be vaccinated pregnant or could she become pregnant within the next month?		YES	No
11. Has the person to be vaccinated ever had Guillain-Barre syndrome?		YES	NO
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)?		YES	NO
13. Has the person to be vaccinated received any other vaccinations in the past 4 weeks?		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 _____

FOR OFFICE USE		VIS Date 7-26-2014	
Route (Circle one)+ IM or Intranasal (IN)	Body Site (circle one) = RD, RV, LD, LV or IN		
Manufacturer _____ Medimune	Lot No. CH2023		
Signature and Title of Person Administering vaccine: _____ Date: _____			