FLU VACCINE CONSENT FORM – 2015-2016

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 I n 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 8-7-2015**

Route (Circle one)+ IM or Intranasal (IN) **Body Site** (circle one) = RD, RV, LD, LV or IN

Manufacturer __Medimune_____ Lot No. _____

Signature and Title of Person Administering vaccine: _____ **Date:**_____