ACADIANA URGENT CARE CENTER

Live Intranasal Influenza Vaccine Consent Form 2015-2016

SECTION A: INFORMATION		
Name (Last, First, Middle):		
Date of Birth: / /	Age (2-49):	Gender: M F

SECTION B: HEALTH HISTORY - please check yes or no for each question.	YES	NO
1. Are you between the ages of 2 to 49?		
2. Are you currently pregnant or a nursing mother?		
3. Do you have heart disease?		
4. Do you have lung disease: asthma or chronic bronchitis? Are you under 5 yrs with asthma or one or more wheezing episodes over the last yr?		
5. Do you have kidney or liver disease?		
6. Do you have a metabolic disease, such as diabetes?		
7. Do you have anemia and/or other blood disorders?		
8. Have you ever had a serious allergic reaction ro eggs?		
9. Do you have any muscle or nerve disorders (such as seizure disorders or cerebral palsy) that can lead to breathing or swallowing problems?		
10. Do you have an immune disorder, such as: AIDS, HIV, and Cancer or have had an organ transplant?		
11. Do you come in close contact or live with someone with a weakened immune system?		
12. Do you have Guillain-Barre syndrome (GBS)?		
13. Are you currently receiving aspirin or aspirin-containing therapy?		
14. Have you ever had a severe reaction after a dose of influenza vaccine?		
15. Are you currently ill or have an elevated temperature?		
16. Do you have any allergies? Please list:		
17. Additional comments:		

SECTION C: CONSENT FOR VACCINATION	
I have read both the Recommendations and the Warnings and side Effects for the Intranasal Influenza Vaccine Information sheets. I have had the opportunity to ask questions and understand the benefits, risks, and possible side effects of the intranasal influenza vaccine. I have been given the opportunity to consult with my personal physician prior to administration. I also understand that there is no guarantee that I will not contract influenza or experience adverse side effects from this vaccine. I hearby give my consent for the intranasal influenza vaccine to be administered, 0.2 ml (standard dose), intranasal to me.	
Signature:	Date: / /
Parent/Legal Guardian Print Name:	Relation:
Witness Signature:	Date: / /

FOR OFFICE USE ONLY - recommended for age 2- 49	LOCATION: ON-SITE OFF-SITE
Manufacturer:	Lot Number:
Site of Injection - Deltoid: R L	Temp:
Administered by:	Date: / / Time: