# CONSENT FOR THE INTRANASAL INFLUENZA VACCINE

I have read the information about the influenza vaccine. I have had the opportunity to ask questions which were answered to my satisfaction. I understand the benefits and risks of the vaccine and request that the vaccine be given to me or to the person named below for whom I am authorized to make the request. I authorize St Clair Pediatrics, LLC to submit documentation for payment of this service to my insurance carrier and I agree to pay St Clair Pediatrics, LLC in the event that this service is not covered benefit on my insurance policy.

## PATIENT INFORMATION

______________________ Last Name ______________________ First Name ______ MI ____________ Age

______________________ Street Address ____________ City ______ State ________ Zip ____________ Phone

______________________ Signature of Parent or Legal Representative ______________________ Relationship to Patient ____________ Date

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Today's Health: □ Good □ Other (explain): ______________________________________________

Has the patient been on Tamiflu in the past two weeks? □ Yes □ No
Is the person receiving the FluMist vaccine allergic to eggs? □ Yes □ No
Is the person the receiving the FluMist vaccine recently administered an MMR or Chickenpox vaccine? □ Yes □ No
Is the person receiving the FluMist vaccine currently receiving chemotherapy? □Yes □ No
Has the patient received the FluMist vaccine before? □ Yes □ No

If no, please be advised that two doses administered at least one month apart are recommended for children $\leq$ 9 years of age who are receiving influenza vaccine . for the first time.

Does the person receiving the influenza vaccine have any of the following conditions?

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| Daily aspirin therapy | □ Yes □No | History of Guillain-Barre Syndrome | □Yes □ No | Pregnancy | □Yes □No |
| Asthma | □Yes □ No | Disease of immune system | □Yes □No | Diabetes | □Yes □No |
| Sickle Cell Disease | □ Yes □No | Daily steroid therapy | □ Yes □ No | Renal Disease | □Yes □No |
| Cancer including Leukemia | □ Yes □No | | | | |

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## OFFICE USE ONLY

Temperature: ____________________ ° F Time: ________________ AM PM

Office Address: ***4941 Benchmark Centre Drive, Suite 100 Swansea, Illinois 62226***

Date vaccine administered: ________________ Site of administration: *Intranasal*

Vaccine Manufacturer: ***MedImmune*** Lot Number: ***501103P*** Expiration Date***: 11 DEC 2011***

Signature of vaccine administrator: ____________________________ Title: ________________