

Bucks County Influenza Vaccination Consent Form

Please complete and return this form (PLEASE PRINT).

Name of child: _____ Birth date: _____ Gender: M ___ F ___

Address: _____

City: _____ State: _____ ZIP Code: _____

Parent/Legal Guardian Name (Last) _____ (First) _____

Daytime Phone Number: _____ Home telephone: _____

School Name: _____ Grade: ___ Homeroom Teacher's Name: _____

Please circle YES or NO to the questions below:

- | | | |
|---|-----|----|
| 1. Is your child severely allergic to eggs? | Yes | No |
| 2. Has your child ever had a severe reaction to an influenza vaccine? | Yes | No |
| 3. Has your child ever had Guillain-Baré syndrome? | Yes | No |
| 4. Does your child have any serious allergies? _____ | Yes | No |
| 5. Does your child have asthma or recurrent or active wheezing? | Yes | No |
| 6. Is your child under 18 years of age currently receiving aspirin or aspirin containing therapy? | Yes | No |
| 7. Has your child received either the MMR, varicella, yellow fever, or FluMist vaccination in the past 30 days? Date: _____ | Yes | No |
| 8. Does your child have any of the following long-term health problems? | | |

(PLEASE CIRCLE)

heart disease lung disease kidney disease metabolic diseases (eg, diabetes)
other _____

- | | | |
|---|-----|----|
| 9. Is your child pregnant or nursing? | Yes | No |
| 10. Does your child or does he/she have close contact with anyone who has a severely weakened immune system that must be in a protective environment (eg, an individual who has had a bone marrow transplant). Please describe: | | |

I have been given the Centers for Disease Control and Prevention Vaccine Information Sheets. I have read these documents and have no further questions at this time. I request and voluntarily consent that influenza vaccine be given to _____ of whom I am the parent or legal guardian.

I want my child to receive (please choose ONE):

- Influenza Shot ONLY
 Nasal Mist ONLY
 Either the influenza shot or the Nasal Mist

IF you answered YES to questions 1, 2, or 3 your child should NOT receive a flu vaccine. If you answered YES to questions 5-11, your child should NOT receive the nasal mist flu vaccine and is able to get the flu shot.

Name of parent: _____ Signature of Parent or Legal Guardian: _____

Date: _____

Are you interested in knowing why certain questions are on the Influenza Vaccination Consent Form? If so, please read the information below. If you have additional questions, consult your health-care provider.

1. Is your child allergic to eggs, egg proteins?

History of anaphylactic reaction—such as hives, wheezing, or difficulty breathing, or circulatory collapse or shock (not fainting)—after eating eggs is usually a contraindication for further doses. Please check with your health-care provider to see if your child has allergies that would prevent immunization against influenza disease.

2. Has your child ever had a serious reaction to any influenza vaccine (shot or nasal mist)?

Patients reporting a serious reaction to a previous dose of influenza vaccine should be asked to describe their symptoms. Immediate—presumably allergic—reactions are usually a contraindication to further vaccination against influenza.

Fever, malaise, myalgia, and other systemic symptoms most often affect persons who are first-time vaccinees. These mild-to-moderate local reactions are not a contraindication to future vaccination.

3. Has your child ever had Guillain-Baré syndrome?

It is prudent to avoid vaccinating persons who are not at high risk for severe influenza complications but who are known to have developed Guillain-Baré syndrome (GBS) within 6 weeks after receiving a previous influenza vaccination. As an alternative, physicians might consider using influenza antiviral chemoprophylaxis for these persons.

5. Does your child have asthma or recurrent or active wheezing?

The nasal mist influenza vaccine is not recommended for children with possible reactive airways disease (eg, history of asthma or recurrent wheezing or whose parent or guardian answers yes to this question). Instead, they should be given the flu shot vaccine.

6. Is your child under 18 years of age currently receiving aspirin or aspirin containing therapy?

Because of the theoretical risk of Reye's syndrome, children and teens on aspirin therapy should not be given the nasal mist influenza vaccine. Instead they should be vaccinated with the flu shot.

7. Has your child received a vaccine within the past 30 days?

Persons who were given a live virus vaccine (MMR, MMRV, varicella, yellow fever, or Flu Mist) in the past 4 weeks should wait 28 days before receiving another live virus vaccine (eg, the FluMist vaccine).

8. Does your child have any long-term health problems?

Persons with any of these health conditions (listed in question 8) should not be given the nasal mist vaccine. Instead, they should be vaccinated with the flu shot.

9. Is your child pregnant or nursing?

It is recommended that pregnant women receive flu shot. Pregnant women or women planning to become pregnant within a month should not be given the nasal mist. If you have any concerns, please consult your child's health-care provider.

10. Does your child have or is in close contact with anyone who has a severe weakened immune system?

The flu shot is preferred for persons who have close contact with severely immunosuppressed persons during periods in which the immunosuppressed person requires care in a protective environment or who are immunosuppressed themselves.

If you have any questions regarding influenza vaccination, please contact your child's health-care provider.