FLUMIST VACCINE PERMISSION SLIP

NAME:_____SEX:___BIRTH DATE:_____ AGE_____

ADDRESS:_____TELEPHONE:_____

_____

PHYSICIAN:_____

Please Circle Each Answer

1. Are you allergic to eggs? YES NO
2. Have you had a severe reaction to any flu vaccine in the past? YES NO
3. Are you under age 2 or over age 49? YES NO
4. Do you have asthma, chronic lung or heart problems, or a metabolic problem such as diabetes, kidney disease, or blood disease? YES NO
5. In the past 12 months, for children 2 – 4 years of age, has your doctor stated that your child has wheezing or asthma? YES NO
6. Are you ill today? YES NO
7. Do you have an immunodeficiency problem? YES_____NO
8. Are you pregnant?__YES_____NO
9. Are you in close contact with a person with severe immunosuppression that requires protective surroundings? YES NO
10. Are you aged 2 – 17 and receiving aspirin therapy? YES NO

I have been given a copy and have read or have had explained to me the information about FluMist vaccine. I have had a chance to ask questions which were not answered in the literature to my satisfaction. I believe I understand the benefits and risks of the FluMist vaccine and request that it is given to me.

SIGNATURE:_____

RELATIONSHIP TO VACCINEE:_____

DATE VACCINATED:_____**MANUFACTURER: Astra Zeneca**
LOT NUMBER: MH2201
EXPIRATION DATE: 12/16/2020

Nurse:_____