

2015-2016 INTRANASAL (LIVE) INFLUENZA VACCINE CONSENT FORM

Information about person to be vaccinated (please print)

Last Name: _____ Age: _____
 First Name: _____ Sex: ___M ___F
 Date of Birth: _____ Phone # _____
 Address _____
 City _____ Zip _____

For child: Parent's name _____

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Child needs second dose _____

Assess if child needs second dose _____

Clinic : _____

The South Dakota Immunization Information System (SDIIS) is an automated system to document vaccinations given in South Dakota. SDIIS will give parents access to their child's immunization record from any participating South Dakota provider. SDIIS also allows providers to send reminder notices regarding needed immunizations. Health care providers, health care facilities, federal or state agencies, welfare agencies, school or family day care facilities may have access to this information in accordance with applicable HIPAA Privacy Act standards and requirements. Immunization records remain confidential, and any person who fails to protect this information is guilty of a Class 1 misdemeanor. If you choose NOT to have your/your child's immunization record shared with other providers, you may request a refusal form.

For a child being vaccinated - check any that apply. (Check here if none apply) _____

Enrolled in Medicaid Please provide Medicaid # _____ American Indian or Alaskan Native
 Does not have health insurance Health insurance that DOES NOT pay for vaccines

**** Please answer the following questions for the person (age 2-49) who will be vaccinated**

	Yes	No	Don't Know
1) Is the person sick today? _____	___	___	___
2) Does the person have an allergy to eggs or to a component of influenza vaccine? _____	___	___	___
3) Has the person ever had a serious reaction to intranasal influenza vaccine (FluMist) in the past? _____	___	___	___
4) Is the person younger than age 2 years or older than age 49 years? _____	___	___	___
5) Does the person have a long-term health problem; heart disease, lung disease (including asthma), kidney disease, neurologic, liver disease, metabolic disease(e.g. diabetes), anemia or other blood disorder? _____	___	___	___
6) If the person is a child 2 years through 4 years, in the past 12 months has a healthcare provider told you the child had wheezing or asthma? _____	___	___	___
7) Does the person have cancer, leukemia, HIV/AIDS, or any another immune system problem; or, in the past 3 months, have they taken medications that weaken the immune system, such as prednisone, other steroids drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis or anticancer drugs; or have they had radiation treatments? _____	___	___	___
8) Is the person receiving influenza antiviral medications? _____	___	___	___
9) Is the child or teen to be vaccinated receiving aspirin therapy or aspirin-containing therapy? _____	___	___	___
10) Is the person pregnant or could she become pregnant within the next month? _____	___	___	___
11) Has the person ever had Guillain-Barre syndrome? _____	___	___	___
12) Does the person live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g., an isolation room of a bone marrow transplant unit)? _____	___	___	___
13) Has the person received any other vaccinations in the past 4 weeks? _____	___	___	___

I have been provided a copy of and have read or have had explained to me the information about influenza and the vaccine listed below. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request.

Signature _____ **Date** _____

(Parent or guardian if minor)

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	Date/Time	Vaccine, Manufacturer, CPT Code	Vaccine Lot number	Route	Date of VIS Publication	Signature of person administering vaccine
INFLUENZA		Flu Mist/MedImmune CPT 90672		Intranasal	08/07/15	