Laurelhurst PTA Seasonal Influenza Vaccination Clinic Compliance and Consent Form
(Note: A separate form is required for EACH person who wishes to be vaccinated)
You must be 6 months old to receive influenza vaccine.

Vaccine Recipient's Name _____ Age_____ Date of birth_____

Select one: ☐ Laurelhurst student ☐ parent ☐ sibling ☐ other relative ☐ none/teacher

Laurelhurst Student's Name (if different from vaccine recipient)_____

Parent or guardian's Name (if different from vaccine recipient)_____

Address _____ Phone:_____

The following questions will help us to determine whether you or your child can receive the Inactivated Flu Vaccine ("flu shot") or the Nasally delivered flu vaccine ("Flumist"). Please mark YES or NO for each question. **"You" refers to the vaccine recipient**.

	YES	NO
1. Have you ever had an allergic reaction to eggs or egg products?	☐	☐
2. Have you ever had Guillain-Barre syndrome?	☐	☐
3. Do you have a moderate/severe illness, with or without fever; or an active neurological disorder?	☐	☐
4. Are you allergic to gentamicin, streptomycin, gelatin or arginine?	☐	☐

If you answered YES to any question from #1 through #4, STOP; you should NOT receive any flu vaccine.
If you answered NO to all four questions, continue.

	YES	NO
5. Have you had a respiratory illness or fever within the last 3 days?	☐	☐
6. Are you less than 17 years old and receiving aspirin or aspirin-containing medicine?	☐	☐
7. Do you have immune system problems or are you/ taking medicines that lower immunity, including chronic oral steroids?	☐	☐
8. Will you come into close contact (e.g., live in same house/room) with immunocompromised individuals for 3 weeks following vaccination?	☐	☐
9. Are you younger than 2 or older than 49?	☐	☐
10. Will you be pregnant during flu season?	☐	☐

If you answered YES to any question from #5 to #10, you should NOT receive Flumist, but may receive the traditional flu shot.

	YES	NO
11. Do you have asthma, recurrent wheezing, diabetes, or other chronic disease?	☐	☐

If you answered YES to #11 AND you would prefer to receive Flumist, please speak with one of the doctors at the clinic to determine whether the traditional flu shot or Flumist is best.

12. Are you under 9 and had no or only one dose of flu vaccination previously?	☐	☐

If you answered YES to #12, then you should receive a booster dose in mid-December

Consent for Influenza Immunization

I have read the Vaccine Information Statements for the flu shot and Flumist. I have had a chance to ask questions, which were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and request that the following vaccine be given to me or the person named below for whom I am authorized to make this request:

☐ Flu shot ONLY ☐ Flumist (nose spray) ONLY ☐ EITHER Flu shot OR Flumist

_____ _____/_____/_____
Signature of person authorized to make request Date

_____ _____
Date of administration Signature of vaccine administrator

Vaccine	Route	Vaccine Manufacturer	Lot #	Expiration Date
TIV / LAIV	IM / Nasal			