

**Olive Branch Family Medical Center
Consent for Nasal Influenza Vaccine
AGE REQUIREMENTS 5-49 YEARS**

PERSON TO RECEIVE VACCINE: _____ AGE: _____

NAME OF SCHOOL: _____ GRADE: _____

PARENT: _____ DAYTIME PHONE: _____

BEFORE YOU CAN RECEIVE FLUMIST, YOU MUST READ THE INFORMATION SHEET AND ANSWER ALL OF THE QUESTIONS. THE HEALTHCARE PROFESSIONAL WILL REVIEW EACH FORM AND DECIDE IF THE PERSON IS A CANDIDATE FOR FLUMIST. THE HEALTHCARE OFFICE WILL KEEP THE QUESTIONNAIRE AND ALL INFORMATION COLLECTED IN A CONFIDENTIAL MANNER. THERE ARE RISKS ASSOCIATED WITH ALL VACCINES, INCLUDING FLUMIST. LIKE ANY VACCINE, FLUMIST DOES NOT PROTECT 100% OF INDIVIDUALS VACCINATED. IN STUDIES OF PEOPLE BETWEEN THE AGES OF 5 AND 49 YEARS, SIDE EFFECTS WERE GENERALLY MILD AND TEMPORARY. RUNNY NOSE WAS THE MOST COMMON. OTHER COMMON SIDE EFFECTS INCLUDED VARIOUS COLD-LIKE SYMPTOMS, SUCH AS HEADACHE, COUGH, SORE THROAT, TIREDNESS/WEAKNESS, IRRITABILITY, AND MUSCLE ACHES.

PLEASE ANSWER YES OR NO TO ALL QUESTIONS REGARDING THE RECIPIENT OF THE VACCINE.

1. ARE YOU ALLERGIC TO EGGS? _____
2. HAS A DOCTOR EVERY TOLD YOU THAT YOU HAVE AN IMMUNE SYSTEM DISORDER? _____
3. DO YOU HAVE A HISTORY OF ASTHMA OR REACTIVE AIRWAY DISEASE? _____
4. DO YOU HAVE ANY CONDITION THAT MAKES YOU SUSCEPTIBLE TO ANY DISEASE? _____
5. DO YOU HAVE ANY LUNG DISEASE INCLUDING CHRONIC BRONCHITIS, EMPHYSEMA, OR CYSTIC FIBROSIS? _____
6. HAVE YOU EVER BEEN DIAGNOSED WITH GUILLAIN-BARRE SYNDROME (A SEVERE PARALYTIC ILLNESS ALSO CALLED GBS)? _____
7. DO YOU HAVE KIDNEY DISEASE? _____
8. ARE YOU PREGNANT OR NURSING? _____
9. DO YOU HAVE HEART DISEASE (ANGINA, CONGESTIVE HEART FAILURE) OR HAVE YOU EVER HAD A HEART ATTACK OR STROKE? _____
10. DO YOU HAVE A BLOOD DISEASE LIKE SICKLE CELL DISEASE OR THALASSEMIA? _____
11. DO YOU CURRENTLY HAVE A RESPIRATORY ILLNESS OR A FEVER? _____
12. HAVE YOU RECEIVED ANY VACCINES WITHIN THE LAST MONTH OR DO YOU PLAN TO RECEIVE ANY WITHIN THE NEXT MONTH? _____
13. ARE YOU TAKING ANY PRESCRIPTION MEDICINES TO PREVENT OR TREAT INFLUENZA? _____
14. IF YOU ARE UNDER 18 YEARS OF AGE, ARE YOU CURRENTLY RECEIVING ASPIRIN OR ASPIRIN-CONTAINING THERAPY? _____
15. DO YOU HAVE DIABETES OR OTHER METABOLIC DISEASE? _____
16. DOS ANY ONE LIVING WITH YOU HAVE A COMPROMISED IMMUNE SYSTEM? _____
17. ARE YOU IN CLOSE CONTACT WITH SEVERELY IMMUNOCOMPROMISED INDIVIDUALS REQUIRING A PROTECTIVE ENVIRONMENT (SUCH AS BONE MARROW TRANSPLANT PATIENT)? _____

ADDITIONAL COMMENTS: _____

IF YOU ANSWERED YES TO ANY OF THE QUESTIONS, A PHYSICIAN WILL BE CALLED TO DETERMINE IF FLUMIST IS RIGHT FOR YOU.

**OLIVE BRANCH FAMILY MEDICAL CENTER
CONSENT FOR NASAL INFLUENZA VACCINE
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I HAVE READ THE PREVIOUS INFORMATION ABOUT FLUMIST AND HAVE TRUTHFULLY ANSWERED ALL OF THE QUESTIONS ON THIS FORM. I HAVE ALSO HAD A COPY OF THE 2007-2008 VACCINE INFORMATION SHEET MADE AVAILABLE FOR ME ON THE WEBSITE FOR FLUMIST. I UNDERSTAND THE BENEFITS AND RISKS OF VACCINATION WITH FLUMIST AND MY SIGNATURE BELOW INDICATES MY PERMISSION FOR FLUMIST TO BE GIVEN TO THE ABOVE NAMED RECIPIENT.

SIGNATURE OF RECIPIENT (IF 18 YEARS OR OLDER)

DATE

SIGNATURE OF PARENT OR GUARDIAN

DATE

PLEASE READ THE VACCINE INFORMATION STATEMENT. IF YOU HAVE OTHER QUESTIONS OR CONCERNS, YOU MAY VISIT FLUMIST.COM OR CONTACT OUR OFFICE AT 662-893-8479.

WE ACCEPT VISA, AMERICAN EXPRESS, DISCOVER, AND MASTERCARD. PLEASE MAKE CHECKS PAYABLE TO OLIVE BRANCH FAMILY MEDICAL CENTER. THE COST IS \$30.00 PER VACCINE, AND MAIL TO 9075 SANDIDGE CENTER COVE OLIVE BRANCH, MS. 38654

TYPE OF CREDIT CARD _____ CARD NUMBER _____

EXPIRATION DATE: _____ AMOUNT TO BE CHARGED: \$30.00

**DEADLINE FOR RECEIPT OF FORMS AND PAYMENT IS
SEPTEMBER 7, 2007.**

**WE WILL BE SCHEDULING THE DATES AND TIMES WITH THE
SCHOOLS FOR VACCINE ADMINISTRATION.**