

## Influenza Vaccine Consent Form-FLU SHOT and NASAL SPRAY

NAME (Last)	(First)	(M.I.)	DATE OF BIRTH
ADDRESS			
CITY	STATE	ZIP	
FOR DISTRICT USE ONLY: SCHOOL:	GRADE:	TEACHER:	

Please mark YES or NO for each question.

The following four questions will help us to know if you can get the influenza vaccine. If you answer "NO" to all of them, you can get the seasonal influenza vaccine. If you answer "YES" to one or more of the following questions, you may be able to get the seasonal influenza vaccine.	YES	NO
1. Do you have a serious allergy to eggs?		
2. Do you have any other serious allergies? Please list: _____		
3. Have you ever had a serious reaction to a previous dose of flu vaccine?		
4. Have you ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?		
<b>There are two kinds of seasonal influenza vaccine. Your answers to the following questions will help us know which of the two kinds of vaccine you can get.</b>		
1. Have you been vaccinated with any vaccine (not just flu) within the past 30 days? Vaccine: _____ Date given: _____ month _____ day _____ year _____		
2. Do you have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood?		
3. Do you have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)?		
4. Are you pregnant?		
5. Do you have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?		

### CONSENT FOR VACCINATION:

I have read or had explained to me the 2013-2014 Vaccine Information Statement for the seasonal influenza vaccine and understand the risks and benefits.

My signature below provides consent to Lake County Public Health, LSSD and their staff to vaccinate my child or myself (for district staff). (If this consent form is not signed, your child/ you will not be vaccinated). My signature also indicates that I will not hold Lake County and the school district liable for expected or unexpected side effects of vaccination.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### This section for administrative use only

Vaccine	Route	Date Dose Administered	Manufacturer	Lot Number	Name and Title of Vaccine Administrator
Influenza	<input type="checkbox"/> IM <input type="checkbox"/> Intranasal		Sanofi-Pasteur		