

Ascension Borgess Hospital

Intranasal Influenza Virus Immunization Consent

Age 2 years through 17 years

Please Print

| | | | |
|-----------|------------|--------|--------------|
| Last Name | First Name | Middle | Phone Number |
|-----------|------------|--------|--------------|

| | | | |
|----------------|------|-------|----------|
| Street Address | City | State | Zip Code |
|----------------|------|-------|----------|

| | | |
|---|-----|---|
| Birthdate ____--____--____ Month Day Year | Age | Gender <input type="checkbox"/> Male <input type="checkbox"/> Female |
|---|-----|---|

| | |
|--|--|
| Name of Insurance (ex: Medicare, BCBS, United Healthcare, Priority Health, etc.) | |
|--|--|

| | |
|------------------|-----------------------------|
| Member ID Number | Group Number (if available) |
|------------------|-----------------------------|

| | |
|---------------------------------|------------------------|
| Provider Network (if available) | Policy/Contract Number |
|---------------------------------|------------------------|

If insurance is not in patient's name, complete the following information

| | | |
|----------------|---|---|
| Insured's Name | Insured's Birthdate ____--____--____ Month Day Year | Relationship to Insured <input type="checkbox"/> Spouse <input type="checkbox"/> Child |
|----------------|---|---|

Please turn page over

Staff Use Only

Administered by _____
Nurse Signature / Title *Date* *Time*

0.1 ml into each nostril (total dose – 0.2 ml) MedImmuneFluMist K L M

Non-Insurance Payment

Amount Paid: \$ _____ Cash Check # _____ Bill Patient

Billing/payment information verified by _____ Clinic No. _____
(initials)

COVID-19 health screen questions answered Temperature checked



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Patient Name _____

Please circle the correct answer on the right

| | | |
|--|----|-----|
| 1. Is the child sick today or running a temperature of 101°F or over? | No | Yes |
| 2. Has the child ever had a life-threatening reaction to a flu vaccine? | No | Yes |
| 3. Is the child severely allergic to eggs or egg products? | No | Yes |
| 4. Does the child have a known allergy to gentamicin sulfate, gelatin or arginine? | No | Yes |
| 5. Does the child have a history of Guillain Barre Syndrome? | No | Yes |
| 6. Is the patient under 2 years old or over 17 years of age? | No | Yes |
| 7. Is the patient possibly pregnant? | No | Yes |
| 8. If the child is under 5 years old: Does he/she have a history of recurrent wheezing? N/A | No | Yes |
| 9. Does the child have a weakened immune system or live with someone who has a severely weakened immune system? | No | Yes |
| 10. Is the child receiving long-term treatment with steroids or cancer treatment with x-rays, radiation or drugs? | No | Yes |
| 11. Is the child taking aspirin therapy or aspirin-containing products? | No | Yes |
| 12. Has the child received antiviral therapy within the past 48 hours? | No | Yes |
| 13. Is the patient taking Tamiflu, Relenza, amantadine, rimantadine, or any T-cell inhibitor medication for psoriasis? | No | Yes |
| 14. Has the child received a live viral vaccine within the past month (adenovirus, influenza flu mist, MMR, rotavirus, smallpox, typhoid, varicella, or yellow fever)? | No | Yes |
| 15. Does the child have diabetes, kidney disease, anemia or other blood disorders, heart, or lung disease (including asthma)? | No | Yes |

- I have read and received a copy of the Live Intranasal Vaccine Information Statement prior to the child's vaccination.
- I understand the risks and benefits involved. I have had a chance to ask questions and you answered them to my satisfaction. I want you to give the vaccine to the child.
- I agree to have the child stay in the general area for fifteen (15) minutes after receiving the vaccination. This is to watch for any reaction that may occur right away. We can't ensure that immediate reactions will not occur. I agree to take the child to their regular doctor or seek emergent care if the child has any unusual or severe side effects. This is at my expense.
- The Ascension Borgess Notice of Privacy Practices gives you information about how we use and disclose medical information about the child. By signing this form you are acknowledging that a copy was made available to you.
- Parent or guardian accepts responsibility for revaccination. Two doses administered at least one month apart are recommended for children less than 9 years old who are receiving influenza vaccine (shot or nasal spray) for the first time or who received their first dose in a previous year, but did NOT get a second dose in the same season.
- I understand that FluMist recipients should avoid close contact (within the same household) with severely immunocompromised individuals for at least seven (7) days.

X _____
 Signature of person authorized to make this request for above child. Relationship to child receiving vaccine Date Time