CCUSD FLU VACCINE SCREENING AND CONSENT FORM FOR 2014-15

Healthy people 2 years of age to 49 years of age are eligible to receive the Nasal Flu Mist.
People 50 years of age or older are only eligible to receive the inactivated Flu Shot.

_____ _____ _____ M / F
Print name of individual to be vaccinated (Last name, First name) **Birthdate** **Age** **Gender**

School/site: OCD EM ER FA LB LH CP MS HS DO Grade____ Classroom_____ Teacher_____

Part A - HEALTH INFORMATION:

Does the person being vaccinated have any of the following health conditions? ☐ YES, mark all that apply below ☐ NO

_____ Asthma (wheezing if under 5 years of age or others requiring daily preventative medications) or Lung Disease
_____ Heart disease
_____ Kidney disease
_____ Metabolic disease (including Diabetes)
_____ Weakened immune system (steroid therapy, under cancer treatment, HIV, etc.)
_____ Live with or expect to have close contact with a person whose immune system is severely weakened and who must be in a protective environment?
_____ Taking anti-viral medications within the last 48 hours (such as Tamiflu, Relenza, amantadine, or rimantadine)
_____ Persons under 18 years of age taking long-term aspirin treatment
_____ Received MMR, Varicella or live flu vaccine within the last 4 weeks
_____ Currently pregnant or breastfeeding
_____ Severe allergic reaction to eggs or previous flu vaccine

If you checked "YES" to any of the health conditions listed above, you cannot receive the nasal FluMist; you may be eligible to receive the inactivated Fluvirin PF flu shot. Please answer the following four questions:

Is the individual being vaccinated currently pregnant or breastfeeding?	☐ YES	☐ NO
Is the individual being vaccinated severely allergic to eggs or latex?	☐ YES	☐ NO
Has the individual being vaccinated had a serious reaction to a previous flu vaccination?	☐ YES	☐ NO
Does the individual being vaccinated have a history of a Guillain-Barre′ Syndrome?	☐ YES	☐ NO

If you checked "YES" to any one of the above questions, we cannot administer the Fluvirin PF Flu vaccine. You may be able to receive a different flu vaccine. Please consult with your doctor.

Part B - PREVIOUS FLU VACCINE INFORMATION: (*Only if person being vaccinated is under 9 years of age)*

Did your child under 9 receive a vaccination for flu last year? ☐ YES* ☐ NO

*_If yes_, how many doses of the flu vaccine did your child get last year? ☐ 1 dose** or ☐ 2 doses (skip to Part C)

**_If only one dose_ last year, did your child receive a flu vaccine the previous year? ☐ YES (skip to Part C) ☐ NO

If your child is under 9 years of age and has not previously been vaccinated for the flu with 2 doses of either the nasal mist or injection, they will need a second vaccination in 4 weeks.

I hereby give consent for the second flu vaccine for my child under 9. Parent/Guardian initials here: _____

Part C – WRITTEN CONSENT:

I have read the current Influenza Vaccine Information Statement (VIS) dated 08/19/2014 and understand the benefits and risks of flu vaccination. I also understand that this immunization will be recorded on the California Immunization Registry, which can be viewed by other healthcare professionals. I agree to these terms and consent to the administration of the flu vaccine.

If requesting this vaccine for a child under the age of 18, I hereby give my permission for the flu vaccine to be administered and certify that I am authorized to make this request. **Parent/Guardian initials here: _____**

_____ _____
Signature of person requesting vaccination **Date**

REQUIRED INFORMATION: for data entry - First name of Mother (of person being vaccinated): _____

for LA County data collection - Ethnicity (of person being vaccinated): _____

FOR CLINIC USE ONLY:

	Location:	Date:	By:	Date 2nd dose given:
FluMist (LAIV)	Intranasal		KA PS DC	
Flu Injection 0.5ml IM (inactivated)	L / R Deltoid		KA PS DC	L / R

Brands: FluMist®, Lot #CJ2003, Exp date: 12/15/14 Fluvirin® PF injection, Lot #145004, Exp date: 03/31/2015