Anne Arundel County Department of Health

Elementary School FluMist® Influenza Vaccination Project
Consent Form

Teacher's Name: _____

Child's Last Name: _____ Child's First Name: _____

Child's Address: _____ ZIP Code: _____

Date of Birth: _____ Age: _____ Child's School: _____ Grade: _____

Medical Insurance: Please check one. (For information purposes only; your insurance will not be billed.)

My child is covered by: □ Private Medical Insurance □ Medical Assistance □ No Medical Insurance

Medical History: Please answer all of the following questions. Check Yes or No.
You may need to contact your family physician to discuss your child's medical history.

1. Does your child have any health problems with heart disease, lung disease (such as asthma or cystic fibrosis), kidney disease, cancer, diabetes or metabolic disease, or blood disorders (such as anemia or sickle cell disease)?	❍ Yes ❍ No
2. Does your child have a weakened immune system?	❍ Yes ❍ No
3. Does your child have a severe allergy to eggs or egg products?	❍ Yes ❍ No
4. Is your child on long-term aspirin therapy?	❍ Yes ❍ No
5. Does your child have a history of Guillain-Barré syndrome?	❍ Yes ❍ No
6. Has your child had an allergic reaction to a previous flu vaccine?	❍ Yes ❍ No
7. Does your child have a muscle or nerve disorder (such as seizures or cerebral palsy) that can lead to breathing or swallowing problems?	❍ Yes ❍ No

If you answered **YES** to **ANY** of the above questions, your child **is not eligible** to receive the nasal flu vaccine. If you answered **NO** to **ALL** of the questions and would like for your child to be vaccinated at school, please sign below and return this form to your child's teacher by **Wednesday, October 8, 2014.**

For children under 9 years of age:

► Has your child received two or more total doses of seasonal flu vaccine since July 2010?
Yes____ No____ Don't know____

Statement of Consent:

"I have received and read the Vaccine Information Statement about the nasal flu vaccine. I understand that this vaccine is approved for healthy children. I have reviewed the reasons why some children shouldn't get the nasal vaccine and none of those reasons apply to my child. I agree to have my child vaccinated with a nasal flu vaccine and with a second dose, if indicated."

Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____Date: _____

Health Clinic Use Only				
Date of VIS 8/19/14	Manufacturer MedImmune	Lot #	Date Given	Site Intranasal
Signature & Title of Vaccine Administrator			Clinic Site:	
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