McLaren Medical Group
NASAL MIST INFLUENZA VACCINE
CONSENT/ADMINISTRATION

Last Name: _____ First Name: _____ Sex: ❑ Male ❑ Female

Address: _____

City : _____ State: _____ Zip: _____

Telephone: (_____) _____ Physician: _____

Date of Birth: _____ Medicare Number (if applicable) : _____

Not all individuals requesting the flu vaccine can safely be immunized against influenza. Please complete the following questions to evaluate any contraindication:

For any YES response: If active patient at this site, review with the provider. Otherwise, refer the patient back to their PCP.

❑ I have reviewed and authorize vaccine administration.

Primary Care Provider (PCP) Signature_____ Date_____Time_____

1.	Have you ever had a severe reaction to a previous influenza vaccine? Describe: _____	❑ Yes	❑ No
2.	Are you allergic to eggs, chicken feathers, chicken or chicken dander?	❑ Yes	❑ No
3.	Are you allergic to Latex?	❑ Yes	❑ No
4.	Do you have a fever or active illness?	❑ Yes	❑ No
5.	Do you have a chronic illness?	❑ Yes	❑ No
6.	Do you have a past history of Guillain-Barre Syndrome?	❑ Yes	❑ No
7.	Are you pregnant?	❑ Yes	❑ No
8.	Have you received another type of vaccine in the past fourteen (14) days?	❑ Yes	❑ No
9.	Are you under the age of eighteen (18)?	❑ Yes	❑ No
10.	Are you currently receiving blood thinners such as Coumadin, aspirin or heparin?	❑ Yes	❑ No
11.	Do you have asthma and/or have you experienced a wheezing episode in the last 12 months?	❑ Yes	❑ No

The intranasal influenza virus vaccine is a live quadrivalent (containing four strains recommended by the U.S. Public Health Service) that is nasally administered as an active immunization for the prevention of influenza.
As with any medication, there are risks and possible side effects/reactions. Studies have shown generally mild and temporary side effects. Runny nose was the most common. Others include various cold-like symptoms, such as headache, cough, sore throat, tiredness/weakness, irritability, and muscle aches. Additional side effects could be possible.

Having received nasal mist influenza vaccine information (dated 8/7/15) and informed consent, I hereby agree to release and hold McLaren Medical Group, its employees, agents and representatives harmless from further responsibility with regard to my receiving the nasal mist. If you should have a reaction, CONTACT YOUR PRIMARY CARE PROVIDER.

I have read the above information and have had the opportunity to ask questions. I understand the benefits and risks of the influenza vaccine as described. I request the flu vaccine to be given to me or to the person named for whom I am authorized to sign.

DOSAGE/ADMINISTRATION

Age Group	Vaccination Status	Dosage Schedule	
Children ages 2 through 8 years	Has not received at least 2 doses of trivalent or quadrivalent influenza vaccine before July 1, 2015	2 doses (0.2 ml each) 4 weeks apart	Date of 1st dose _____ Lot# _____ Exp. Date: _____ By _____ Date of 2nd dose _____ Lot# _____ Exp. Date: _____ By _____
Children ages 2 through 8 years	Has received at least 2 doses of trivalent or quadrivalent influenza vaccine before July 1, 2015	1 dose (0.2 ml) per season	Date given _____ Lot# _____ Exp. Date: _____ By _____
Children and adults ages 9 through 49 years	Not applicable	1 dose (0.2 ml) per season	Date given _____ Lot# _____ Exp. Date: _____ By _____

PAYMENT AGREEMENT

I understand that the nasal mist flu vaccine may not be covered by my insurance. If not, I accept responsibility for payment.

_____ _____
Signature: Patient or Authorized Representative (Relationship) Date

ORIGINAL - Center CANARY - Patient