

FluMist Assessment & Consent Form

Provided by Visiting Nurse Association Home Support Services

IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS NOTIFY THE NURSE BEFORE IMMUNIZATION:

- Y N
- Are you less than 2 years of age or greater than 49 years of age?
- Have you ever had a reaction to the flu vaccine?
- Are you allergic to eggs or egg products, MSG, arginine, gentamicin or gelatin?
- Are you a child or adolescent receiving aspirin therapy or aspirin-containing therapy?
- Do you have asthma, reactive airways disease, lung disease, or if under the age of five, have had one or more episodes of wheezing in the past year?
- Do you have a history of heart disease, a metabolic disease, such as diabetes, kidney or liver disease, anemia or other blood disorders, have a weakened immune system or are receiving immunosuppressive therapies, have seizures or cerebral palsy?
- Do you have a nasal condition serious enough to make breathing difficult, such as a stuffy nose?
- Are you pregnant or a nursing mother?
- Are you sick with a fever greater than 100 degrees Fahrenheit?
- Do you plan on donating blood in the next 2 weeks?
- Have you been diagnosed with Guillain-Barre' syndrome?
- Have you received another immunization in the past month? *If yes, please list* _____
- Have you taken an influenza antiviral agent in the last 48 hours?
- Are you on any medications? *Please list* _____
- Have you ever had a severe allergic reaction to anything (re: hives, difficulty breathing, shock) requiring Emergency medical treatment or within 48 hours to a previous vaccine? *If yes, please specify* _____

QUESTIONS

If you have any questions about the Influenza disease or the FluMist immunization, **please ask the nurse for clarification now** or call your doctor before requesting the vaccine. **If you have any questions or concerns following immunization, please call the Visiting Nurse Association at 248-967-8751. If you experience any adverse effects from the FluMist immunization, please contact your physician and notify the Visiting Nurse Association (also notify your employer if you received your immunization at work).**

CONSENT AND RELEASE FOR INFLUENZA VACCINE

- I have read the information regarding the influenza immunization. I have had an opportunity to ask questions, and my questions have been answered to my satisfaction. I understand the benefits and risks of Influenza immunization as described. I request that the vaccine be given to me. I understand the immunization is being provided by Visiting Nurse Association Home Support Services (VNA). **I expressly release VNA from any liability resulting from the Influenza vaccine itself.**
- I agree to remain under observation for at least 15 minutes. Should I leave before that period lapses, I expressly release VNA from any liability resulting from any adverse reaction to the vaccine which may occur during that period and thereafter. I understand that if I experience any side effects, it will be my responsibility to follow up with my physician at my expense. I understand side effects may include, but are not limited to: runny nose, nasal congestion, fever in children 2 – 6 years of age, and sore throat in adults. There is some risk for Guillain-Barre Syndrome. Severe reactions may include anaphylaxis and death.
- In the event a VNA employee is exposed to my blood or other body fluids, I agree to have my blood tested for HIV and Hepatitis and have the results released to VNA/exposed person but not to anyone else unless required/authorized by law.
- I acknowledge that I have received written information on VNA's "Notice of Privacy Practices" prior to the provision of service, and I have had the opportunity to have my questions answered.
- **I acknowledge that I am responsible to reimburse the VNA for charges not covered by my insurance** _____.
- **I agree to give a copy of this consent form to my employer (if applicable).**

_____ Male Female ___/___/___ _____ _____
Name (Last, First, Middle) Birth Date Age Weight

_____ _____ _____ _____
Street Address / Apt. No. City/State Zip Code Telephone Number

_____ _____
Medicare ID Number or Insurance ID & Group Responsible Party or Cardholder Information & Birth date
Name

_____ _____ _____
Signature of Client Date Payment & Volunteer Initial

TO BE COMPLETED BY THE NURSE OR CLERK

Clinic: _____ Date _____ Yes No I have received a flu shot in the past.

Dose: 2 years – 49 years

0.25cc FluMist Intranasal (approx. 0.125 in each nostril)

_____ _____
Lot No/Exp. Date Signature of Nurse Giving Injection/Date