



CONSENT FOR THE INTRANASAL INFLUENZA VACCINE

I have read the information about the influenza vaccine. I have had the opportunity to ask questions which were answered to my satisfaction. I understand the benefits and risks of the vaccine and request that the vaccine be given to me or to the person named below for whom I am authorized to make the request. I authorize St Clair Pediatrics, LLC to submit documentation for payment of this service to my insurance carrier and I agree to pay St Clair Pediatrics, LLC in the event that this service is not covered benefit on my insurance policy.

PATIENT INFORMATION				
_____	_____	_____	_____	
Last Name	First Name	MI	Age	
_____	_____	_____	_____	_____
Street Address	City	State	Zip	Phone
_____	_____	_____		_____
Signature of Parent or Legal Representative	Relationship to Patient	Date		

Today's Health: Good Other (explain): _____

Has the patient been on Tamiflu in the past two weeks? Yes No

Is the person receiving the FluMist vaccine allergic to eggs? Yes No

Is the person the receiving the FluMist vaccine recently administered an MMR or Chickenpox vaccine? Yes No

Is the person receiving the FluMist vaccine currently receiving chemotherapy? Yes No

Has the patient received the FluMist vaccine before? Yes No

If no, please be advised that two doses administered at least one month apart are recommended for children ≤ 9 years of age who are receiving influenza vaccine . for the first time.

Does the person receiving the influenza vaccine have any of the following conditions?

Daily aspirin therapy <input type="checkbox"/> Yes <input type="checkbox"/> No	History of Guillain-Barre Syndrome <input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnancy <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	Disease of immune system <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No
Sickle Cell Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Daily steroid therapy <input type="checkbox"/> Yes <input type="checkbox"/> No	Renal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer including Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No		

OFFICE USE ONLY	
Temperature: _____ ° F	Time: _____ AM PM
Office Address: 4941 Benchmark Centre Drive, Suite 100 Swansea, Illinois 62226	
Date vaccine administered: _____	Site of administration: <i>Intranasal</i>
Vaccine Manufacturer: MedImmune	Lot Number: 501103P Expiration Date: 11 DEC 2011
Signature of vaccine administrator: _____	Title: _____