Clinician ______ School Nurse ______

Howard County Consent for 2015-2016 Nasal Influenza Vaccine (FluMist)

Please Print Clearly in Ink

Student's Name (Last)	(First)	(M.I.)	Student's Date of Birth ___/___/___	Age ______	Sex F M
Parent/Guardian Name (Last)	(First)	(M.I.)	Home Phone		Cell Phone
Address			Teacher		Grade
City	ZIP Code		School Name		

INSURANCE INFORMATION – PLEASE FILL OUT COMPLETELY AND ACCURATELY

Please provide this information from your insurance card. We must bill your insurance company. You will NOT be charged for a co-pay or a deductible.

Type of Insurance: ☐ Private Insurance ☐ Medicaid/Medical Assistance ☐ My child does not have health insurance (Your child will not be turned away because of no insurance)

Insurance Company	Member ID	Group Number	Effective Date of Insurance
Policy Holder's/Insured Adult's Name	Relationship to Student		Policy Holder's Date of Birth

1. Do any of the following apply to your child? *(If you answer YES to any question, your child cannot receive FluMist.)*

Yes	No		Yes	No	
☐	☐	Allergy to eggs	☐	☐	Is on long-term aspirin or aspirin-containing therapy (for example, does your child take aspirin every day)?
☐	☐	Allergy to Gentamincin, gelatin, or arginine	☐	☐	Has had Guillain-Barre syndrome (very rare) within 6 weeks of receiving a flu vaccine
☐	☐	Has had a serious reaction to flu vaccine in the past	☐	☐	Has a weak immune system (for example, from HIV/AIDS, cancer, or medications such as steroids or those used to treat cancer)
☐	☐	Currently has asthma, diabetes (or other metabolic disease), or disease of the lungs, heart, blood, kidneys, liver, nerves (neurologic or neuromuscular) or an episode of wheezing in the past year	☐	☐	Pregnant

Yes	No	
☐	☐	2. Will your child have close contact with a person with a severely weakened immune system? (For example, someone who has had a bone marrow transplant)
☐	☐	3. Has your child received any other vaccination within the past four weeks? If so: Which vaccine? ____________ Date of Vaccine? ____________

For Children Under 9 Years Old:
Has your child received two or more doses of influenza (flu) vaccine before July 1, 2015? ☐ Yes ☐ No ☐ Unknown

If you have any questions about flu vaccine, please contact your child's doctor or call the local health department. You also may find information at the Maryland Department of Health and Mental Hygiene at www.dhmh.state.md.us or www.flu.gov.

CONSENT FOR VACCINATION

By signing this form, I give permission for my child to be vaccinated and I agree that:
(1) The information above is correct;
(2) I have read the "2015-16 Live Nasal Influenza Vaccine Information Statement (VIS)" dated 8/7/15 or someone has read it to me;
(3) I understand the risks and benefits of getting the live nasal influenza vaccine; and
(4) Any question I had about the vaccine have been answered.

Signature of Parent/Legal Guardian______________________ Date: ____/____/____

Vaccination Record FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Dose Administered	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator	Date VIS given to parent/guardian
2015-16 LAIV	/ /	MedImmune			/ /