

# FluMist Consent Form

Return this form to your student's school as soon as possible.

**Please complete information below, sign, and return to your child's school.**

\*\*\*\*\*

Student's Name: \_\_\_\_\_  
Last
First
MI
Date of Birth
Age

Mailing Address/PO Box \_\_\_\_\_

Street Address \_\_\_\_\_  
City
State
Zip

School \_\_\_\_\_  
Teacher
Grade
Student's Sex (M/F)

1. Does your student have an allergy to eggs or to flu vaccine?  Yes  No
2. Has your student had a serious reaction to FluMist in the past?  Yes  No
3. Does your student have a long-term health problem-- asthma, heart disease, lung disease, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorders?  Yes  No
4. Is your student younger than 5 and have doctor diagnosed asthma?  Yes  No
5. Is your student 5 and older and had one or more episodes of **wheezing** within the past year?  Yes  No
6. Does your student have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long term treatment with drugs such as steroids, or cancer treatment with x-rays or drugs?  Yes  No
7. Does your student receive long-term (daily) aspirin therapy?  Yes  No
8. Is your daughter pregnant or could she become pregnant in the next month?  Yes  No  N/A
9. Has your student ever had Guillain-Barré Syndrome (GBS)? (If you do not know what this is, your student has not had it.)  Yes  No

**FluMist is free of charge. The following are for survey purposes only:**

10. Your child has Medi-Cal or is eligible for the CHDP program  Yes  No
11. Your child has private health insurance  Yes  No
12. Your child is Native American or Alaskan Native  Yes  No

**Consent for Flu Mist:** I have been given a copy and have read, or have had explained to me, the information contained in the CDC Vaccine Information Statement. I have had a chance to ask questions which were answered to my satisfaction. I have no further questions at this time. I believe I understand the benefits and risks of the FluMist vaccine. I request and voluntarily consent that the vaccine be given to me or to the person named for whom I am authorized to make this request. I acknowledge that no guarantees have been made concerning the vaccine's success. I hold harmless the school district, school site, and individual administering the vaccine. I understand the side effects and warnings of the vaccine.

**Please Print:**

Parent or Guardian Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Parent or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

FOR CLINIC USE ONLY							
Date	Dose	Vaccine / Mfg	Lot#	Exp.Date	Screening MD/RN/LVN	IZ Given by	Site / Route
							Intranasal



**AMADOR COUNTY PUBLIC HEALTH  
ACKNOWLEDGMENT OF RECEIPT  
OF NOTICE OF PRIVACY PRACTICES**

**Patient or Subscriber Name:** \_\_\_\_\_  
(Please print patient or subscriber name)

**I,** \_\_\_\_\_  
(Print name of patient, subscriber, conservator, parent or legal guardian signing below)

**hereby acknowledge receipt of the Notice of Privacy Practice from:**

**Immunizations/TB Testing**

**Sign:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**If not signed by patient, indicate relationship:** \_\_\_\_\_

**FOR OFFICE USE ONLY**

NOTE: Parents must have legal custody. Legal guardians and conservators must show proof.

**THIS SECTION TO BE FILLED OUT ONLY BY AMADOR COUNTY PUBLIC HEALTH**

**Patient did receive the Notice of Privacy Practices, but did not sign this Acknowledgment of Receipt because:**

- Patient left office before Acknowledgment could be signed.
- Patient does not wish to sign this form.
- Patient cannot sign this form because: \_\_\_\_\_

**Patient did not receive the Notice of Privacy Practices because:**

- Patient required emergency treatment.
- Patient declined receipt of the Notice and does not wish to sign this form.
- Other: \_\_\_\_\_

**Name:** \_\_\_\_\_  
(Print name of provider or provider's representative)

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(Signature of provider or provider's representative)