Montgomery County Department of Health and Human Services
School Health Services

Consent for Seasonal Nasal Spray Flu (FluMist) Vaccination(s)

Dear Parent / Guardian;
Please complete this form if you want your child to receive seasonal nasal flu (Flu Mist) vaccine(s).

Child's Last Name:	Child's First Name:	Age:	Grade:
Address:	Home Phone: Cell Phone: Work Phone:	Date of Birth:	
Teacher:	**Has your child ever had a flu vaccine before?** ☐YES ☐NO **Did they receive only one dose of flu vaccine the first time they had the flu vaccine?** ☐YES ☐NO		

For maximum protection against influenza the Centers for Disease Control (CDC) recommends that children under 9 years old, who are getting seasonal influenza vaccine (FluMist) for the first time, receive a second dose in 4 weeks. CDC also recommends that children under the age of 9 who only received 1 dose in their first year of vaccination receive 2 doses in the following year.

If you answer **YES to ANY** of the questions below, your child is **NOT** eligible to receive the nasal seasonal flu vaccine, however your child may receive the injectable seasonal flu vaccine.
If you answer **NO to ALL** of the questions and would like your child to receive the seasonal nasal flu vaccine, please sign below.

1. Does your child have any significant chronic or long-term illnesses involving the kidneys, heart, nervous system, brain, diabetes, lungs, (like cystic fibrosis), or blood system (like sickle cell anemia)?	☐YES	☐NO
2. **Does your child have asthma?**	☐YES	☐NO
3. Does your child have a severe allergy to egg products, Gentamycin, gelatin, arginine or to a previous flu vaccine?	☐YES	☐NO
4. Is your child taking medicine containing aspirin?	☐YES	☐NO
5. Does your child have a history of Guillian-Barre syndrome?	☐YES	☐NO
6. Is your child scheduled to receive MMR, Varicella, FluMist, or Yellow Fever vaccines in the month following this nasal spray vaccination?	☐YES	☐NO
7. Has your child received the vaccines listed in question '6' in the past month?	☐YES	☐NO
8. Does your child live with someone who is undergoing a stem cell transplant or bone marrow transplant?	☐YES	☐NO
9. Is your child pregnant?	☐YES	☐NO

FluMist can not be administered to any child who is ill on the day of the vaccination clinic.

Statement of Consent:

I have received and read the Vaccine Information Statement (VIS) about the seasonal nasal flu vaccine. I have had a chance to ask questions about the vaccine. I understand that this vaccine is approved for healthy children and have reviewed the reasons some children should not get the seasonal nasal flu vaccine. None of these reasons apply to my child. I agree to have my child vaccinated with the seasonal nasal flu vaccine.

Name of parent / guardian: _____ **Signature of parent / guardian**: _____ **Date**: _____

* * * * * * Office Use Only * * * * * *

Vaccine	Mfgr/ Lot #	Exp. date	Dose/ Route	VIS Date
1st dose **Influenza (Intranasal)**	**MedImmune**		**0.2 ml intranasally**	
2nd dose **Influenza (Intranasal)**	**MedImmune**		**0.2 ml intransally**	

2nd Dose Required: if less than 9 years old **and NO or only one previous** flu vaccine	Yes	No

1st Vaccine administered by: _____ Date: _____ 2nd Vaccine administered by: _____ Date: _____

06/22/11