HomeCare Plus Medical 864 Wilson Drive, Ridgeland, MS 39157

VACCINE CONSENT AND ADMINISTRATION RECORD

Student Name:_____ Date of Birth:_____

Allergies:_____

***Please note: Insurance does not cover the nasal vaccine unless administered at a physician's office

For adult patients as well as parents of children to be vaccinated: The following questions will help us determine if there is any reason we should not give your student child live intranasal influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	YES	NO	DON'T KNOW
1. Is the person to be vaccinated sick today?	_____	_____	_____
2. Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine	_____	_____	_____
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	_____	_____	_____
4. Has the person to be vaccinated ever had Guillain-Barre Syndrome?	_____	_____	_____
5. Is the person to be vaccinated younger than age 2 years or older than age 49 years?	_____	_____	_____
6. Does the person to be vaccinated have a long-term health problem with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., diabetes), or anemia or another blood disorder.	_____	_____	_____
7. If the person to be vaccinated is a child age 2 through 4 years, in the past 12 months, has a healthcare provider eve r told you that he or she had wheezing or asthma?	_____	_____	_____
8. Does the person to be vaccinated have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as high-dose steroids, or cancer treatment with radiation or drugs?	_____	_____	_____
9. Is the person to be vaccinated receiving antiviral medications?	_____	_____	_____
10. Is the child or teen to be vaccinated receiving aspirin therapy or aspirin-containing therapy?	_____	_____	_____
11. Is the person to be vaccinated pregnant or could she become pregnant within the next month?	_____	_____	_____
12. Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in productive isolation (e.g., an isolation room of a bone marrow transplant unit)?	_____	_____	_____
13. Has the person to be vaccinated receive d any other vaccinations in the past 4 weeks?	_____	_____	_____

I, the undersigned, have received and read a CDC vaccine information statement (http://www.cdc.gov/vaccines/hcp/vis/vis-statements/flulive.pdf) dated 08/07/2015 as of the date indicated below. I understand the risks and benefits related to vaccination of the student child named above of which I am the parent or legal guardian. All questions related to such risks and benefits have been answered to my satisfaction. I acknowledge that no guarantee has been made concerning the vaccine's effectiveness or success. I authorize the administration of the vaccine. I understand that in the event a second dose of vaccine is required, it will be my responsibility to notify HomeCare Plus Medical and arrange a date/time to receive such second dose. I understand that any and all payments for vaccinations are nonrefundable and that prepaid doses will be maintained by HomeCare Plus Medical for a maximum of one week (7 days) after the appropriate date of administration.

For Clinician Use: Vaccine Name: FluMist Manufacturer: MedImmune

Lot #: _____ Exp Date: _____ Date of Administration:_____Vaccinator: _____