**North Atlanta Pediatrics *Influenza FluMist Form for Patients***

1. **Please Print**
2. **Complete all areas of form**
3. **Signature required at bottom of Form**

**This Box for Office Use Only:**

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Flu Vaccine Paid by \_\_\_Cash \_\_\_ Credit Card \_\_\_ Check \_\_\_\_\_\_\_\_ Check #

Amt Paid \_\_\_\_\_\_\_\_\_\_ Child’s Acct # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Appt. Date | | |
| Last Name | First Name | Middle |
| Date of Birth | Age | \_\_\_Male  \_\_\_Female |

|  |  |  |  |
| --- | --- | --- | --- |
| Please check appropriate box: | | Yes | No |
| 1 | Does your child have an egg allergy?  If **Yes**  was it Hives \_\_\_\_\_\_ or Anaphylactic reaction \_\_\_\_\_\_\_ Other?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| 2 | Is your child sick with a fever? |  |  |
| 3 | Does your child have a history of Guillain-Barre Syndrome (GBS)? |  |  |
| 4 | Has your child ever had a serious reaction to a previous vaccination? |  |  |
| **5** | Does your child have an immune disorder, AIDS, HIV, Cancer or Organ transplant? |  |  |
| 6 | Does your child have Asthma, Reactive Airway disease, wheezing, or use an inhaler?  When did they last wheeze or use inhaler? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| 7 | Does your child have any diseases of the lung such as chronic bronchitis, emphysema, or cystic fibrosis? |  |  |
| 8 | Does your child have kidney disease? |  |  |
| 9 | Is your child pregnant? |  |  |
| 10 | Is your child receiving chronic aspirin or aspirin containing therapy? |  |  |
| 11 | Does your child have a history of Heart Disease, Neurological Disease, or history of Seizures? |  |  |
| 12 | Has your child had a live virus vaccine (MMR, Varicella, Proquad or Rotateq) in the last month or plan to have these vaccines in the next month? |  |  |
| 13 | Does your child have Diabetes or any other Metabolic disease? |  |  |
| 14 | Does your child live with anyone who is immune compromised? |  |  |
| 15 | Is your child in close contact with severely immunocompromised individuals such as an bone marrow transplant patient? |  |  |
| 16 | Is your child currently taking any prescription medicines to prevent or treat for flu? |  |  |
| Explain any yes answers on questions 1 through 16: | | | |

***If your child is under 9 years there is a possibility they may need 2 doses - Ask your Health Care Provider***

***There must be at least a 4 week interval between doses***

I have read the Vaccine Information Statement which includes the indications, precautions, possible adverse reactions or complications related to the vaccine. I hereby consent to and authorize North Atlanta Pediatrics to administer this vaccine. I hereby release North Atlanta Pediatrics and its employees from any and all liabilities in connection with this vaccine and its administration to me.

**Signature of consenting parent \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**To be completed by nurse administering the vaccine:**

* All yes answers have been addressed
* Vaccine and lot # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Location given \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Data has been put into GRITS (Must be added manually – Add patient as needed)
* Nurse Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_