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Queen Anne's County Department of Health
Annual Influenza Vaccine Consent Form – NASAL SPRAY

Section 1: Information about Child to Receive Vaccine (please print in blue or black ink)

STUDENT'S NAME (Last)	(First)	(M.I.)	**STUDENT'S DATE OF BIRTH** **Month**_________ **Day**______ **Year**__________		
PARENT/LEGAL GUARDIAN'S NAME (Last)	(First)	(M.I.)	**STUDENT'S AGE**	**STUDENT'S GENDER** **M / F**	**RACE**
ADDRESS			**PARENT/GUARDIAN DAYTIME PHONE NUMBER:**		
CITY	**STATE**	**ZIP**			

SCHOOL NAME	**HOMEROOM TEACHER'S NAME**	**GRADE**

Section 2: Screening for Vaccine Eligibility

Has your child had the flu shot or FluMist after July 1, 2010? YES _________ NO___________

The following questions will help us know if your child can get the intranasal influenza vaccine. **(FluMist)**

Please mark YES or NO for each question.	**YES**	**NO**
1. Does your child have a serious allergy to eggs?	☐	☐
2. Does your child have any other serious allergies? Please list:	☐	☐
3. Has your child ever had a serious reaction to a previous dose of flu vaccine?	☐	☐
4. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	☐	☐
5. Has your child had an MMR or Varicella (chickenpox) shot within the past 30 days? Vaccine:________________________ Date given: Month _________Day__________Year________		
6. Does your child have any of the following: **asthma, diabetes** (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood? Specify:		
7. Is your child on long-term aspirin or aspirin-containing therapy (for example, does your child take aspirin every day)?		
8. Does your child have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)?		
9. Is your child pregnant?		
10. Does your child have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?		

Section 3: Consent

I have read or had explained to me the Vaccine Information Statement for the live seasonal influenza vaccine and understand the risks and benefits.

☐ **I GIVE CONSENT** to the Queen Anne's County Department of Health and its staff for my child named at the top of this form to be vaccinated with this vaccine and acknowledge receipt of Notice of Privacy Practice form. (If this consent form is not signed, then your child will not be vaccinated).

Signature of Parent/Legal Guardian____Date:Month________Day________Year_______

*****DO NOT RETURN THIS FORM TO SCHOOL IF YOUR CHILD IS NOT TO RECEIVE FLUMIST*****

Section 5: Vaccination Record

FOR ADMINISTRATIVE USE ONLY

Vaccine	Route	Date Dose Administered	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator
Influenza (LAIV)	Intranasal	/ /	Med Immune		
Influenza (LAIV) (2nd dose)	Intranasal	/ /	Med Immune		

Revised August 2018