



**2009-2010 FluMist (Influenza Virus Vaccine Live, Intranasal)  
Vaccination Consent Form**

**ST. JOHN'S MERCY  
CORPORATE HEALTH**

Please complete and return this form **WITH ATTACHED CHECK**  
(Unless your child participates in the free and reduced lunch program)

Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_ School: \_\_\_\_\_

Check this box if your child participates in the free or reduced lunch program:

Please print the child's information below that is receiving the vaccination.			
First Name	M.I.	Last Name	Home Phone Number
Date of Birth	Emergency Contact Number /		
Street Address	Mother's Name		Father's Name
City	State	Zip Code	Guardian if under 18 Relationship

**Please answer each question below. Your child is not eligible for the Warren County School District vaccine program if you answer yes to any of the questions. Please discuss the answers with your child's health care provider and he/she can determine the proper vaccine for him/her.**

1. Has your child received any immunization within the past 30 days? Yes      No  
If yes, please list the name of the vaccine(s): \_\_\_\_\_
2. Has your child received a flu vaccination since August 1, 2009? Yes      No
3. How old is your child? \_\_\_\_\_
4. Is your child allergic to any part of the vaccine? Yes      No  
(eggs, egg proteins, gentamicin, gelatin, or arginine)
5. Has the child ever had a life-threatening reaction to an influenza vaccine? Yes      No
6. Is your child under 18 years of age currently receiving aspirin or aspirin-containing therapy? Yes      No
7. Does your child have asthma, recurrent wheezing or active wheezing? Yes      No
8. Has your child ever had Guillain-Barre syndrome? Yes      No
9. Does your child have any diseases (for example: cancer, lupus, HIV/AIDS) or take a medication (for example: steroids or chemotherapy) that lowers the body's resistance to infection? Yes      No
10. Does your child have any of the following long-term health problems? (Check Circle)  
 Heart Disease       Kidney Disease       Metabolic Diseases (for example: Diabetes)  
 Other \_\_\_\_\_
11. Does your child have close contact with anyone who has a weakened immune system (for example: and individual who has had a recent bone marrow transplant or is currently receiving chemotherapy)?  
If yes, Please describe: \_\_\_\_\_
12. Does your child have any allergies/medical alert? Yes      No  
If yes, please list: \_\_\_\_\_

Your child should receive 2 flu vaccinations at least one month apart if he/she is **under the age of nine and has never been vaccinated against influenza before. Circle this sentence if this applies to your child.**

*Request for administration of FluMist for the above-named recipient:* I have been given the 2009-2010 CDC Vaccine Information Statement and the SJMMC's Notice of Privacy Practices. I have read these documents and have no further questions at this time. I understand the risks and benefits of live intranasal influenza vaccine. I request and voluntarily consent that the vaccine be given to \_\_\_\_\_, of whom I am the parent or legal guardian, and I acknowledge that no guarantees have been made concerning the vaccine's success. I understand the side effects and warnings of the vaccine.

Name of child: \_\_\_\_\_ Age of child: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Name of Parent: \_\_\_\_\_ Signature of Parent: \_\_\_\_\_

**Please return this form to your school by October 9, 2009.**

Date of Vaccination: \_\_\_\_\_ Lot #/Expiration Date/Manufacturer: \_\_\_\_\_

Signature of Nurse: \_\_\_\_\_ Date: \_\_\_\_\_