

COUNTY LOGO

SCHOOL \_\_\_\_\_  
 HOME ROOM TEACHER \_\_\_\_\_  
 GRADE \_\_\_\_\_

**PLEASE PRINT**

Child's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Gender \_\_\_\_\_ Parent Phone \_\_\_\_\_ Parent Name \_\_\_\_\_  
 Child's Age \_\_\_\_\_ Child's Month, Day, & Year of Birth \_\_\_\_\_

<p align="center"><b>Please answer YES or NO to all questions.</b></p> <p>Your answers will help us determine if there is any reason we should not give your child intranasal influenza vaccine. A nurse will review the information before vaccination. If you have questions, please call your healthcare provider or local health department at 5XX-XXX-XXXX.</p>	Parent	Nurse
1. Has your child received a vaccine within the past 4 weeks? Vaccine Name: _____ Date received: _____		
2. Has your child received a FLU vaccination before? _____ Date received: _____		
3. Is your child younger than 5 years of age?		
4. Has your child ever been diagnosed with asthma or reactive airway disease?		
5. Does your child have any of the following: Chronic heart diseases, kidney disease, lung diseases, blood diseases, or diabetes or other metabolic diseases		
6. Has your child ever had a reaction to an injection?		
7. Is your child allergic to eggs, gelatin, or other components of influenza vaccine?		
8. Is your child pregnant or nursing?		
9. Has your child ever had Guillain-Barre' syndrome?		
10. Is your child on long-term aspirin therapy?		
11. Does your child have any of the following: Cancer, lupus, HIV/AIDS, or Do they take a medication that lowers the body's resistance to infection?		
12. Does your child have contact with anyone who has had a bone marrow transplant in the last 6 months?		

I have received, read and had my questions answered about the Vaccine Information Statement for the vaccine to be given. I request that the vaccine be given to the above named person, for whom I am responsible. My relationship to the child is \_\_\_\_\_. I also allow the release of any information needed to process insurance claims or request payment of medical benefits. I allow the Oregon Department of Human Services to use and release this information to bill for received vaccines.

\_\_\_\_\_  
**Parent/Guardian Signature** \_\_\_\_\_ **Date**

AREA FOR OFFICAL USE ONLY			
Vaccine Naïve (circle) Yes No	Lot# _____ Exp Date _____ Vaccine <u>FluMist</u> Site, Route & Amt _____ Date given _____ Signature/Provider # _____	Manufacturer <u>Medimmune</u> VIS Date _____	