400 McCaslin, #103 * Louisville, CO 80027 * Phone (303) 666.7337 * Fax (303) 666.7379

Date: _____

CONSENT FOR TREATMENT
INFLUENZA VACCINE (INACTIVATED) OR FLUMIST
COMPLETE THIS FORM FOR PERSON RECEIVING VACCINATION

Are you a patient of Centennial Valley Pediatrics? __ Yes __ No
We do require payment for treatment at time of service for Parents or Non-Patients
Check your method of Payment: Check# _____ Credit Card _____ Cash _____
$30.00 for FluMist or Flu Vaccine (Visa-MasterCard-Discover)

I request that: Name: _____ Date of Birth: _____
Age: _____ Phone # _____ Address: _____
City: _____ State: _____ Zip: _____
receive the (please check one) __ Influenza Vaccine __ Flu Mist
If not your child, what is your relationship? _____
Child's Insurance Company Name _____ Do we have this insurance on file at our office? ____

E. George RN, S. Powell MA, J. Rose MA, N. McKelvie LPN, L.Synder MA, Jill Kuzma MA, H. Smith LPN, J. Winfrey LPN, Nancy Smith CPNP, Evelyn Swanton CPNP
MD _____

Date Vaccine and VIS given: _____ Informed to return for #2 vaccine after: _____
VIS Date: Inactivated Flu Vaccine **7/26/2011** Live Intranasal Influenza Vaccine **7/26/2011**

FluMist One spray (0.10cc) to each nostril Lot# _____ Expiration Date: _____

Sanofi PF (0.25cc) Flu Vaccine Lot# _____ Expiration Date: _____
R Th.IM, L TH.IM, R Delt.IM, L Delt. IM

Sanofi PF (0.50cc) Flu Vaccine Lot# _____ Expiration Date: _____
R Th.IM, L TH.IM, R Delt.IM, L Delt. IM

Sanofi Regular Flu Vaccine (0.25cc) Lot# _____ Expiration Date:
R Th.IM, L TH.IM, R Delt.IM, L Delt. IM

Sanofi Regular Flu Vaccine (0.50cc) Lot# _____ Expiration Date:
R Th.IM, L TH.IM, R Delt.IM, L Delt. IM

The following questions will help us determine if there is any reason we should not give you or your child the Influenza Vaccine or the Intranasal Vaccine (FluMist) 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.

Patient Name: _____ Date of Birth: _____

1. Have you ever had a flu vaccine or flumist before? __Yes __No
2. Do you currently have a fever, respiratory illness or any other type of infection? __Yes __No
3. Does the person to be vaccinated have an allergy to eggs, latex or a component of the influenza vaccine, including Thimerisol? __Yes __No
4. Has the person to be vaccinated ever had a serious reaction to Intranasal influenza vaccine or another vaccine? __Yes __No
   If yes, please list the adverse reaction _____
5. Is the person to be vaccinated younger than age 2 or older than age 49? __Yes __No
6. Does the person to be vaccinated have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (E.G. diabetes), anemia or other blood disorders? __Yes __No
7. Is the person to be vaccinated a child age 2 through 4 years with a history of wheezing? __Yes __No
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 steroids, or cancer treatment with x-rays or drugs? __Yes __No
9. Is the person to be vaccinated receiving aspirin therapy or aspirin-containing therapy? __Yes __No
10. Is the person to be vaccinated pregnant or could she become pregnant within the next month? __Yes __No
11. Has the person to be vaccinated ever had Guillain-Barre Syndrome? __Yes __No
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 a protective environment (such as in a hospital room with reverse air flow)? __Yes __No
13. Has the person to be vaccinated received any other vaccinations in the past 4 weeks? __Yes __No

I have read the above information about FluMist and the Influenza Vaccine and have truthfully answered all of the questions on this form. I have had a chance to ask questions and fully understand the benefits and risks of the FluMist and Influenza Vaccine. I agree that Centennial Valley Pediatrics shall have no responsibility or liability if I suffer any other adverse reaction following administration of the Flu Vaccine or FluMist. I have received a copy of the Vaccine Information Statement.

Signature _____ Date _____
Person to receive vaccine or parent/guardian