PREVEA health

Patient Sticker

Screening and Consent Form for Influenza Vaccine/Flu Mist

For Inactivated Flu Vaccine-FLU SHOT	
Do you have a fever or moderate to severe illness today?	☐ Yes ☐ No
Do you have a serious allergic reaction to eggs? (i.e. hives, difficulty breathing, etc.?)	☐ Yes ☐ No
Have you ever had a serious allergic reaction to previous dose of influenza vaccine?	☐ Yes ☐ No
Do you have a history of Guillain-Barre Syndrome (a paralyzing illness?)	☐ Yes ☐ No
Do you have an allergy to latex?	☐ Yes ☐ No

For Live Attenuated Intranasal Flu Vaccine-FLU MIST®			
Do you have a fever or moderate to severe illness today?	☐ Yes ☐ No	Do you have renal (kidney) disease or problems?	☐ Yes ☐ No
Do you have a serious allergic reaction to eggs?	☐ Yes ☐ No	Do you have a blood disorder like anemia or sickle cell disease?	☐ Yes ☐ No
Have you ever had a serious allergic reaction to a previous dose of influenza vaccine?	☐ Yes ☐ No	Do you have a weakened immune system or are immunosuppressed (HIV/AIDS, cancer, organ transplant, etc.)?	☐ Yes ☐ No
Do you have diabetes?	☐ Yes ☐ No	Are you pregnant or breastfeeding?	☐ Yes ☐ No
Are you less than 2 years of age or older than 49 years of age?	☐ Yes ☐ No	Are you a child or adolescent receiving aspirin therapy?	☐ Yes ☐ No
Do you have chronic cardiac disease or history of heart attack or stroke?	☐ Yes ☐ No	Are you taking any prescription medicine to prevent or treat the flu?	☐ Yes ☐ No
Do you have chronic pulmonary (lung) disease (bronchitis, emphysema, cystic fibrosis, etc)?	☐ Yes ☐ No	Are you in close contact with someone who has a SEVERELY compromised immune system?	☐ Yes ☐ No
Do you have asthma or reactive airway disease or are you a child <5 years old with a history of recurrent wheezing?	☐ Yes ☐ No	Have you received any live vaccines within the last month or plan to receive any within the next month? ****Live Vaccines may include:(**Zostavax** (shingles); **MMR** (Measles, Mumps, Rubella); **Proquad** (Measles, Mumps, Rubella, Varicella); **Varivax** (Chicken Pox/Varicella)*	☐ Yes ☐ No
Do you have a history of Guillain-Barre Syndrome (a paralyzing illness)?	☐ Yes ☐ No	*****A YES answer to any question will result in deferral of flu mist*****	

I have read or have had explained to me the information about influenza and/or FluMist®. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks and ask that it be given to me or the person for whom I am authorized to make this request. I agree to remain under observation for at least 15 minutes. Should I leave before that period lapse, I expressly release Prevea Health from any liability resulting from any adverse reaction to the vaccine which may occur during that period and thereafter. I understand that if I experience any side effects, it will be my responsibility to follow up with my physician at my expense. I understand side effects may include, but are not limited to: soreness at the injection site, fever, fatigue, and headache.

Patient's First/Last Name (Print):_____ **Patient's** Date of Birth:_____

Signature of:_____ Print Name of person signing:_____
Patient/Parent/Guardian **(if other than the patient)**

FOR CLINIC/OFFICE USE ONLY

Admin Site: **Intranasal Left Right:**_____ Lot #:_____ Expiration Date: _____

Signature of Administrator:_____ Title:_____ Date:_____ VIS (8-6-2021) Provided: ☐

PRV_112/REV09/19
Send to scanning

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