Olympia Pediatrics 2020-2021 Flu Shot Consent

Please fill out if the patient is going to receive either **the flu shot or Flumist**

YES NO

☐ ☐ Does the patient have a high fever currently or an acute illness?

☐ ☐ Are you concerned the patient has symptoms of COVID (Fever, Cough, Difficulty Breathing, Fatigue, Headaches, Loss of Taste or Smell, Sore Throat, Congestion/Runny nose, Nausea, Vomiting or Diarrhea) or has been directly exposed to COVID in the last 14 days?) **IF YES – Please call the clinic prior to coming in the building. 360-413-8470**

☐ ☐ Has the patient had an anaphylactic allergic reaction to gelatin, eggs or egg products?

☐ ☐ Has the patient had an anaphylactic allergic reaction to the influenza vaccine?

☐ ☐ Does the child have a history of Guillain-Barré syndrome (acute paralysis)?

If the patient is going to receive the **live intranasal influenza vaccine** (Flumist®), please answer the following question, otherwise you may skip these questions:

YES NO

☐ ☐ Is the patient under 2 years of age?

☐ ☐ Has the patient had any vaccination in the last 4 weeks?

☐ ☐ Does the patient have a chronic disease such as heart or lung disease or kidney failure?

☐ ☐ Has this child had recurrent wheezing or been diagnosed with asthma in the past 12 months?

☐ ☐ Does the patient have illnesses that weakens the immune system or take medications that can weaken the immune system, (i.e. HIV, Sickle-Cell Anemia, Asplenia, Immunodeficiency)?

☐ ☐ Does the patient have close contacts and caregivers of severely immunosuppressed persons who require a protected environment?

☐ ☐ Is the patient pregnant?

☐ ☐ Does the patient have an active communication between the CSF and the oropharynx, nasopharynx, nose, or ear or any other cranial CSF leak including a cochlear implant

☐ ☐ Is the patient taking aspirin or aspirin containing products or any influenza antiviral medication within the last week?

If you answered YES to any of the above questions, please discuss this with the clinical staff or doctor

☐ **FLU SHOT - I am choosing to have the inactivated influenza vaccine shot for the patient noted below.**

Possible reactions to influenza vaccine shot:

Mild: Soreness or redness at the site of injection, fever, and body aches.

Severe: Allergic reactions with fever, difficulty breathing, hives, rapid heartbeat. Guillain-Barré Syndrome which is progressive muscle weakness and paralysis which may occur a week after the vaccine (1-2 cases per million persons vaccinated).

☐ **FLU MIST - I am choosing to have the live intranasal influenza vaccine for the patient noted below.**

Possible reactions to live intranasal influenza vaccine:

Mild: Runny nose, cough, body aches, fever, stomachaches, wheezing, fatigue, sore throat, and headache.

Severe: Allergic reactions with fever, difficulty breathing, hives, and rapid heartbeat.

I have read the 2020-2021 Center for Disease Control (CDC) Influenza vaccine information sheet (either inactivated influenza vaccine shot OR live intranasal influenza vaccine) for the vaccine the patient will receive and understand the risks and benefits of the vaccination. I hereby consent to have the influenza vaccine.

Parent Signature:____

Date:_________________________

(Print) Patient Name:____

Date of Birth:____