

**ARKANSAS DEPARTMENT OF HEALTH
2014-2015 INFLUENZA SEASON -- IMMUNIZATION CONSENT FORM**

For ADH use only	ADH Clinic Code: _____	Date Of Service: _____
School Name: _____	School Grade: _____	(If school clinic)

Person Receiving Vaccine:

(Legal) First Name: _____ MI _____ Last _____

Date of Birth: / /

1. MEDICAL HISTORY: Complete the following questions for the individual receiving the vaccine.

	YES	NO	
Have you ever had a serious allergic reaction to eggs? If yes, as a precaution, it is recommended you do not receive the flu vaccine until you have consulted your private healthcare provider.			If any answer is YES, you may not be able to receive the flu vaccine.
Have you ever had a serious reaction to a previous dose of flu vaccine?			
Have you ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?			
Are you younger than 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No			If any answer is YES, you can receive only the <u>injectable</u> flu vaccine (shot), not the intranasal flu vaccine (flu mist).
Are you older than 49 years? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Are you pregnant? If yes, what is the date of your last menstrual period? <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>			
Do you have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood?			
Are you on long-term aspirin or aspirin-containing therapy (for example, do you take aspirin every day)?			
Have you received any of these vaccines in the last 28 days? Measles, mumps, rubella (MMR) <input type="checkbox"/> Yes <input type="checkbox"/> No Varicella (chickenpox) <input type="checkbox"/> Yes <input type="checkbox"/> No Intranasal influenza vaccine (Flu Mist) <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you have a severely weakened immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)?			
Do you have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?			
For parents NOT attending flu clinic with their child:			
If you answered No to all of the above questions, your child may receive either the flu shot (injectable) or flu mist (nasal spray). In school-aged children, flu mist seems to provide greater protection. Please mark your preference of vaccine type below. If your preferred vaccine type is not available or marked, the nurse will give what is available unless you indicate otherwise.			
<input type="checkbox"/> Flu Shot <input type="checkbox"/> Flu Mist <input type="checkbox"/> No Preference <input type="checkbox"/> Do not give if my preference is not available			
Child's Homeroom Teacher: _____ (For school clinic use)			

2. RELEASE AND ASSIGNMENT. Please read the section on the reverse side of this form. The Arkansas Department of Health's Privacy Notice is on the website www.healthy.arkansas.gov, posted and available at the clinic site, or accompanies this form. Then sign on the first line in the box at right.

Please sign here

My signature below indicates I have read, understand and agree to section 2. **Release and Assignment** of the 2014-2015 Influenza Season -- Immunization Consent Form. Consent valid through June 30, 2015.

Signature of Patient/Parent/Guardian: _____ date _____

Signature and Title of Vaccine Administrator: _____ date _____

