PEDIATRIC ASSOCIATES OF OCALA

2725 S.E. Maricamp Road Ocala, FL 34471

Return prior to your appointment at office@paocala.com or via fax at 352-369-8703

INTRANASAL INFLUENZA VACCINE QUESTIONNAIRE AND CONSENT FORM

Appointment Date:_____

Patient's Name:_____ Date of Birth:_____

I have read the information supplied in regards to the vaccine my child will receive at their appointment. I will be given the opportunity to ask any questions I may have and understand any risks involved.

I consent to have the intranasal influenza vaccine given to my child by Pediatric Associates of Ocala.

Screening Checklist for Contraindications to Live Attenuated Intranasal Inactivated Injectable Influenza Vaccination

For use with people age 2 through 49 years: The following questions will help us determine if there is any reason we should not give you or your child live attenuated intranasal influenza vaccine, quadrivalent (LAIV4, 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.

	yes	no	don't know
1. Is the person to be vaccinated sick today?	☐	☐	☐
2. Does the person to be vaccinated have an allergy to an ingredient of the influenza vaccine?	☐	☐	☐
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	☐	☐	☐
4. Is the person to be vaccinated younger than age 2 years or older than age 49 years?	☐	☐	☐
5. Does the person to be vaccinated have a long-term health problem with heart disease, lung disease (including asthma), kidney disease, neurologic disease, liver disease, or metabolic disease (e.g., diabetes)?	☐	☐	☐
6. If the person to be vaccinated is a child age 2 through 4 years, in the past 12 months, has a healthcare provider told you the child had wheezing or asthma?	☐	☐	☐
7. Does the person to be vaccinated have a) an open channel between the cerebrospinal fluid (CSF) and the mouth, throat, nose or ear or any other cranial CSF leak, or b) a cochlear implant, or c) an immunocompromising condition due to any cause (e.g., medication, congenital or acquired imm-immunodeficiency, HIV infection, or a missing or non-functioning spleen [e.g., caused by sickle cell disease])?	☐	☐	☐
8. Is the person to be vaccinated currently taking influenza antiviral medications, or have they taken any within the past 3 weeks?	☐	☐	☐
9. Is the person to be vaccinated a child or teen age 6 months through 17 years and receiving aspirin- or salicylate-containing medicine?	☐	☐	☐
10. Is the person to be vaccinated pregnant or could they become pregnant within the next month?	☐	☐	☐
11. Has the person to be vaccinated ever had Guillain-Barré syndrome?	☐	☐	☐
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 protective isolation (e.g., an isolation room of a bone marrow transplant unit)?	☐	☐	☐
13. Has the person to be vaccinated received any other vaccinations in the past 4 weeks?	☐	☐	☐

Consent / Form Completed By:_____ Date:_____

(Signature of Patient or Patient's Legal Guardian)

Consent / Form Reviewed By:_____ Date:_____