Date: _____________________ Date of birth: _______________________

Patient name: _____________________________________ _______________________________________

Last First

Is your child allergic to eggs? _________

Does your child have asthma? _________

Has your child wheezed or needed a breathing treatment or inhaler in the last year? _______

Has your child had any adverse reaction to vaccines? _______

Does your child have any immune deficiencies or other health problems? _______

Has your child had a flu mist, MMR or chicken pox vaccine in the last 30 days? _______

Is your child currently ill or had a fever in the past 48 hours? _______

Has your child had Guillain – Barre syndrome? _______

Is there a possibility your child could be pregnant? ______

"I have read or have had explained to me information about the indicated vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and ask that the indicated vaccine be given to me or the named person for whom I am authorized to make the request."

Sticker here

Site given:
Intranasal LA RA
LL RL

Signature of vaccine admin: ______________________

Signature of parents: ______________________

H1N1 Vaccine - Flumist