AHN PEDIATRICS
Pediatric Alliance

INTRANASAL FLU VACCINE CONSENT FORM

I voluntarily submit to and authorize PEDIATRIC ALLIANCE to administer the flu vaccine to me/my child for the purpose of immunizing against influenza and have reviewed the Vaccine Information Statement. I have had a chance to ask questions and understand the information presented to me.

I understand that if this is not a covered service under my insurance, that I will be responsible for the cost.

Contraindications:

Check any of the following that apply to you:

- — Under 2 years old or over 49 years old
- — Pregnant women
- — People with asthma or have had wheezing in the past 6 months
- — People who have had a severe allergy to flu vaccines or latex in the past or other severe, life-threatening allergy
- — People who have long-term health problems
- — People with weakened immune system
- — Children or adolescents on long-term aspirin treatment
- — A history of Guillain-Barre Syndrome or active neurological disorder
- — People who are moderately or severely ill
- — People with close contact to a person who is severely immunocompromised
- — Had another vaccine in the past 4 weeks.
- — People who have taken antiviral medication in the past 48 hours

I understand that occasional reactions occur. These may include:

- Systemic reactions: In children and adolescents 2 – 17 years of age, mild reactions including runny nose, nasal congestion or cough, headache and muscle aches, fever, abdominal pain or occasional vomiting or diarrhea may occur.
  Some adults 18 – 49 years of age have reported runny nose or nasal congestion, sore throat, cough, chills, tiredness/weakness, and headache.
- Immediate or allergic reactions: In rare cases, a serious allergic reaction may occur. Signs of a serious allergic reaction may include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heartbeat or dizziness, and require immediate medical attention.

I have read the contraindications above and have discussed any concerns with my healthcare provider.

I understand that I am to report to the nearest Emergency Department if a severe reaction occurs.

Patient Name: _____ **DOB:** _____

Patient/Guardian Signature: _____

Date: _____