MILE HI IMMUNIZATIONS, LLC
283 Columbine Street #150, Denver, CO0206
303-374-3374 phone 303-374-8656 fax

2010 FLUMIST CONSENT FORM

Patient MUST be healthy between the ages of 2-49

NAME LAST (one character per box) NAME FIRST MIDDLE INITIAL

STREET ADDRESS

CITY STATE ZIP

SEX DATE OF BIRTH AGE PHONE

M / F M M / D D / Y Y Y Y

Precautions & Contraindications: Please Shade-In "Yes" or "No" for each question.

1. Are you allergic to eggs? YES ☐ NO ☐
2. Do you have any problems with your immune system? YES ☐ NO ☐
3. Do you have AIDS, HIV, cancer, or have you received an organ transplant? YES ☐ NO ☐
4. Did a doctor ever tell you that you had asthma or reactive airway disease? YES ☐ NO ☐
5. Do you have any disease of the lungs, including chronic bronchitis, emphysema, or cystic fibrosis? YES ☐ NO ☐
6. Did you ever have Guillain-Barre syndrome or an active neurological disease? YES ☐ NO ☐
7. Do you have kidney disease? YES ☐ NO ☐
8. Are you pregnant or nursing? YES ☐ NO ☐
9. Do you have heart disease (angina, congestive heart failure) or have you ever had a heart attack? YES ☐ NO ☐
10. Do you have a blood disease like sickle cell disease or thalassemia? YES ☐ NO ☐
11. Do you currently have a cold or other respiratory illness or fever? YES ☐ NO ☐
12. Have you received any vaccines within the last month or do you plan to receive any within the next month? YES ☐ NO ☐
13. Are you taking any prescription medicines to prevent or treat the flu? YES ☐ NO ☐
14. Does anyone living with you have a compromised immune system? YES ☐ NO ☐
15. Do you have diabetes or other metabolic disease? YES ☐ NO ☐
16. Are you on Aspirin Therapy? YES ☐ NO ☐

BASED ON YOUR RESPONSES TO THE ABOVE QUESTIONS, THE NURSE MAY REFER YOU TO YOUR PHYSICIAN FOR YOUR INJECTION, OR INJECTION MAY BE REFERRED FOR YOUR SAFETY.

I understand the adverse reactions associated with the Influenza vaccine and I am aware that a copy of the vaccine manufacturer's drug information sheet is available at the CDC website. Furthermore, I have also had an opportunity to ask questions about this immunization. I believe that the benefits outweigh the risks and I assume full responsibility for any reactions that may result. My medical record may be shared with my physician/insurance. I waive and release any and all claims I, or anyone claiming by or through me, now have or may hereafter acquire against Mile Hi Immunizations and the clinic site sponsor and their respective parent, subsidiaries, and affiliates, and each of their directors, officers, employees, and agents for any and all damages or injuries arising out of or related to the receipt of the immunization, including, without limitation, if I, the person named below for whom I am authorized to make this request, contract Influenza, other respiratory diseases, or suffer any other damages or adverse reactions, including death, following administration of this immunization. I am requesting that the immunization be given to me or the person named below for whom I am the legal guardian.

X____________________ (Signature/Legal Guardian) Date: ____________

For OBSERVATION: Please remain on the premises for 10 minutes following vaccination. If you leave you are doing so against medical advice. Your safety is our primary concern.

THIS SECTION TO BE COMPLETED BY NURSE

(Please note, if one of the following is NOT a clear choice, shot must be paid for at time of service):

Please Circle One: Customer Employee

If Applicable, Please Choose One: Cash Check Bill Company

NURSE'S INITIALS:____________ TIME GIVEN:____________

LOT #: CLINIC DATE: / / 2 0 1 0