



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

2011 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 in 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: / /