MAXIM HEALTH SYSTEMS® MAXIM HEALTHCARE SERVICES®

Branch: ___-___ Clinic: ______

FLUMIST® CONSENT FORM

First Name: _____ Middle Initial: ___

Last Name: _____

Address: _____

City: _____ State: ___ Zip: _____

Phone: ___-___-____ Birthdate: MM DD YYYY Age: ___ Sex: (M/F) ___

For recipients 18 years of age and under only: Mother's Maiden Name: _____

Precautions and Contraindications: Please check YES or NO for each question.	YES	NO
1. Are you 50 years of age or older or between 6 months and 2 years of age?	☐	☐
2. Are you allergic to eggs, egg proteins, gentamicin, gelatin, arginine, and/or MSG?	☐	☐
3. Do you have a weakened immune system?	☐	☐
4. Are you in close contact with anyone who has severely weakened immune system?	☐	☐
5. Have you ever had a life threatening reaction to a previous influenza vaccination?	☐	☐
6. Do you have asthma or active wheezing?	☐	☐
7. Did you have a history of Guillain-Barré Syndrome or active neurological disorder?	☐	☐
8. Do you have kidney, liver, heart, lung and/or metabolic (diabetes) disease?	☐	☐
9. Are you pregnant or suspect you are pregnant?	☐	☐
10. Do you have anemia or any other blood disorder?	☐	☐
11. Have you received any live vaccines within the last month or do you plan to receive any within the next month?	☐	☐
12. Is your child or adolescents (2-17 years of age) receiving aspirin therapy or aspirin-containing therapy (because of the association of Reye's Syndrome with aspirin and wild type influenza infection)?	☐	☐
13. Are you exhibiting symptoms other than mild coughing, runny nose and/or diarrhea?	☐	☐

If yes to any of the above, you must see your private physician to determine the necessity of receiving FluMist.

INFORMATION REGARDING FLUMIST

Why Get Vaccinated with Influenza Vaccine?

Influenza or the "flu" strikes around 1 in ever 10 persons in the United States each winter. Although it is often confused with the common cold, the flu is more severe. The typical flu includes fever, severe muscle aches, fatigue, headache, cough, sore throat and a runny nose. When an adult of working age gets the flu, it can last as long as 10 days. Most healthy adults recover from the flu without other health complications. Vaccination is recommended as the best way to prevent influenza. Because flu viruses change constantly, flu vaccines also change and the vaccine must be given each year.

What is FluMist and What Benefits Can I Expect?

FluMist is an influenza vaccine that is given as a mist into the nose. FluMist contains three live influenza virus strains, which have been weakened. When the weakened influenza viruses in FluMist enter the nose, the body develops an immune response that may help prevent the flu for the entire season.

ADVERSE REACTIONS

What Side Effects Might Occur?

A vaccine, like any medicine, could possibly cause serious problems, such as severe allergic reactions. The risk of a vaccine causing serious harm, or death, is extremely small. Live influenza vaccine viruses rarely spread from person to person. Even if they do, they are not likely to cause illness. FluMist is made from weakened virus and does not cause influenza. The vaccine can cause mild symptoms in people who get it, such as: runny nose, nasal congestion, sore throat or cough. Fever, wheezing, headache and muscle aches. Chills, tiredness/weakness, abdominal pain or occasional vomiting or diarrhea. Life-threatening allergic reactions from vaccines are very rare. If they do occur, it is usually within a few minutes to a few hours after the vaccination.

Maxim will administer FluMist to healthy children and adolescents 2-17 years of age, and healthy adults, 18-49 years of age. *Children under 9 years of age getting influenza vaccine for the first time should get 2 doses of vaccine at least 1 month apart.*

PAYMENT INFORMATION

☐ 90660 Influenza virus vaccine, live, for intranasal use 90473 Dx V04.81 **AMOUNT PAID $** _____

MFR: _____ **LOT NO.:**_____

Corporate Address: 7227 Lee DeForest Drive, Columbia, MD 21046, Phone No. 866-211-0001 Tax ID No. 52-1968516

CONSENT FOR SERVICES, MEDICAL RECORDS and HIPAA PRIVACY INFORMATION

I have read the adverse reactions associated with the FluMist vaccine. A copy of the vaccine manufacturer's drug information sheet is available on request. Furthermore, I have also had an opportunity to ask questions about this vaccination. I believe 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 am requesting that the vaccination be given to me or the person named below for whom I am the legal guardian. I for myself, my heirs, executors, and assigns hereby release Maxim, any retail site, grocery store, school, school district, pharmacy, corporation, physician and/or medical director and its affiliates, subsidiaries, divisions, directors and employees, from any and all claims arising out of, in connection with or in any way related to my receipt of this or these vaccination. Maxim and the aforementioned related parties shall not at any time or any extent whatsoever be liable, responsible, or in any way accountable for any loss, injury, death or damage to be suffered or sustained by any person at any time in connection with or as a result of this vaccine program.

Maxim will use and disclose your personal and health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed **NOTICE OF PRIVACY PRACTICES** to help you better understand our policies in regards to your personal health information, I acknowledge that I have a received a copy of the Notice of Privacy Practices. I acknowledge that I have received the appropriate Vaccine Information Statement (VIS) issued by the US Centers for Disease Control and Prevention for the vaccine(s) being administered.

FluMist VIS Version Date:_____

I understand that I am to provide a copy of this form to my physician and/or healthcare provider for my permanent health records. I agree to remain in the general area for at least 15 minutes after receiving the vaccine.

X _____ _____

Signature/Legal Guardian Date of Service

_____ _____

Print Name Nurse's Signature