INFLUENZA VACCINE INFORMATION AND RELEASE FORM
Family Physicians of Greeley, PLLP

It is recommended that all children and adults above the age of 6 months be vaccinated with the Influenza Vaccine this year including the following high risk groups:

1. People with chronic, debilitating diseases including:
    - heart disease, diabetes, AIDS, kidney disease or cancer
    - rheumatic heart disease with mitral valve stenosis
    - asthma, chronic bronchitis, pulmonary fibrosis, emphysema, tuberculosis, cystic fibrosis, weak respiratory muscles or other lung diseases
2. People over the age of 65
3. People who are often exposed to influenza, such as medical personnel
4. Anyone who lives with or cares for children less than 6 months of age

IT IS NOT TO BE GIVEN TO THOSE WITH SEVERE <u>ALLERGIES</u> TO CHICKEN EGGS, GENTAMICIN, GELATIN, ARGININE, THIMERSAL in MDVs, OR THOSE WITH A HISTORY OF GUILLAIN BARRE SYNDROME. FLUMIST IS NOT TO BE GIVEN TO PATIENTS WITH ASTHMA

Potential side effects/adverse reactions:

1. Redness, swelling and tenderness at the site of injection for 2 to 3 days after the injection
2. Fever, muscle aches, fatigue or headaches
3. Runny nose or nasal congestion in all ages and sore throat in adults after taking Flumist
4. Guillain Barre Syndrome (characterized by paralysis which usually goes away with time and is reversible)

Please answer the following questions:

	Yes	No
1. Are you ill or do you have a cold?	_____	_____
2. Are you taking cortisone/steroids or radiation/cancer therapy?	_____	_____
3. Do you have a severe allergy to chicken eggs?	_____	_____
4. Have you ever had Guillain Barre Syndrome?	_____	_____
5. Have you ever had a reaction to a Flu Vaccine before?	_____	_____
6. Do you have asthma or other lung disease? (no FluMist)	_____	_____

I have read the above information about the influenza vaccine and the special precautions for allergies and side effects/adverse reactions. I have had the opportunity to ask questions and understand the benefits and risks of the vaccination. I requested that it be given to me or the person's name (listed below) of whom I am the parent or guardian.

_____ _____ _____
PRINT PATIENT NAME BIRTH DATE AGE

_____ _____ _____ _____
ADDRESS CITY STATE ZIP CODE

_____ _____ _____
RELATIONSHIP TO PATIENT SIGNATURE DATE