SEMC INTRANASAL INFLUENZA VACCINATION (FluMist) ADMINISTRATION RECORD

2023/2024 **Information about the person to receive vaccine. Please Print**

Last Name_____First Name _____ MI _____
Address _____ City _____ State _____ Zip _____
Phone Number: _____ Date of Birth _____ Age _____
Family Physician: _____ Primary Clinic:_____ Allergies: _____

Please Answer the Following Questions

1. Are you allergic to eggs or egg products? Yes ☐ No ☐
2. Are you allergic to Thimerosal (A preservative)? Yes ☐ No ☐
3. Have you ever had Guillain-Barre Syndrome? Yes ☐ No ☐
4. Have you been ill or had a fever within the last 48 hours? Yes ☐ No ☐
5. Have you had the fluMist before? Yes ☐ No ☐
   A. If yes, did you have any reaction to the FluMist? Yes ☐ No ☐
   B. If yes, what were the symptoms? _____ C. Symptoms occurred how many years ago? ___
6. Do you have any chronic health conditions, including diabetes, asthma, blood disorder, heart disease, lung disease, kidney disease, neurologic disorder, or liver disease? Yes ☐ No ☐
7. Do you have cancer, leukemia, HIV/AIDS, or any other immune system disorder; or, in the past 3 months, taken medications that affect the immune system, such as Prednisone, other steroids or drugs to treat rheumatoid arthritis, Crohn's disease, psoriasis, or anticancer drugs or Aspirin containing therapy? Yes ☐ No ☐
8. Are you age 2 through 17 years and receiving Aspirin therapy or Aspirin-containing therapy? Yes ☐ No ☐
10. Are you a child age 2 through 4 years, and in the last 12 months experienced wheezing or asthma? Yes ☐ No ☐
9. Are you pregnant or could become pregnant within the next month? Yes ☐ No ☐
10. Are you receiving antiviral medications (Relenza or Tamiflu)? Yes ☐ No ☐
11. Have you received an MMR, Varicella, MMRV, Shingles or Yellow Fever vaccine in the past 4 weeks? Yes ☐ No ☐
12. Do you have a weakened immune system or do you expect to have close contact with someone whose immune systems is severely compromised? Yes ☐ No ☐

If you have had recent chemotherapy, radiation therapy, or steroids (except inhaled), these conditions may decrease the effectiveness of the vaccine. However, unless you physician has told you different, flu vaccination is still encouraged.

I have read or have had explained to me the Vaccine Information Statement about influenza and influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me *Sleepy Eye Medical Center will keep this record.*

Signature: _____ Date: _____

<table>
<tr><td colspan="3">Administrative Use Only:</td></tr>
<tr><td colspan="2">Date Administered/VIS given: _____/_____/_____</td><td>Date of VIS: ____/___/__</td></tr>
<tr><td>Lot#:</td><td>Mfg:
CSL MED
SKB NOV
PMC PSC
GSK</td><td>CPT code:
90662: Fluzone High Dose greater than 65 years (PMC)
90682: FluBlok 18 years and older (PSC)
90686: Fluarix-Quad 6 months and older (GSK)
90672: Flu Mist age 2-49 (MED)
Other:</td></tr>
<tr><td>Route:</td><td>Site:</td><td>Name and title of vaccine administrator:</td></tr>
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