

**SEMC INTRANASAL INFLUENZA VACCINATION (FluMist) ADMINISTRATION RECORD
2024/2025 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: _____

Administrative Use Only:		
Date Administered/VIS given: ____/____/____	Date of VIS: ____/____/____	
Lot#:	Mfg: CSL MED SKB NOV PMC PSC GSK	CPT code: 90660: Flu Mist age 2-49 (MED) Other:
Route:	Site:	Name and title of vaccine administrator: