

# Flu Consent Form

<hr/>	<hr/>	<hr/>	<hr/>	<input type="checkbox"/> Male <input type="checkbox"/> Female
First Name	Last Name	Initial	Date of Birth	
<hr/>			<hr/>	<input type="checkbox"/> Responsible Person
Parent/Guardian Name (if client is a minor)			Date of Birth	
<hr/>		<hr/>	<hr/>	<hr/>
Address		City	State	Zip Code
<hr/>		<input type="checkbox"/> cell <input type="checkbox"/> home <input type="checkbox"/> YES you may send text message reminders to this phone number		
Phone Number				
<hr/>		<hr/>	<hr/>	
Name of Insurance Company		Identification Number	Group Number	
<hr/>		<hr/>	<hr/>	
Name of Policy Holder		Policy Holder's DOB	<b>***NOTE: Without insurance information you will be billed directly for your flu shot.</b>	
<hr/>		<hr/>		

**For patients:** The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please see the back side of this page or ask your healthcare provider to explain it.

YES	NO	N/A	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Have you ever had a severe reaction after receiving a vaccination (i.e., rash, hives, difficulty breathing)? <b>Please list reaction(s):</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (i.e., diabetes), anemia, other blood disorder or a chronic condition you see a provider for? <b>Please list your chronic condition(s):</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Are you sick today with a fever or diarrhea?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? <b>Please list:</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. In the <b>past 3 months</b> , have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments? <b>Please list medication(s):</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6. Do you have allergies to any of the following? <b>Please circle which one(s):</b> latex / neomycin / gentamicin / yeast / gelatin / monosodium glutamate / eggs
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7. <b>For adults:</b> Have you received a Pneumococcal vaccine? <b>Please complete:</b> <input type="checkbox"/> Prevnar 13 Date: _____ (released 08/2014) <input type="checkbox"/> Pneumovax 23 Date: _____ (released 1983)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8. <b>For women:</b> Are you pregnant or a chance you could become pregnant during the next month?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9. Have you had a seizure, a brain, or other nervous system problem?

**\*FOR OFFICE USE ONLY\***

	Site	Lot #		Site	Lot #
Flu / I-Flu / H-Flu:	_____	_____	Pneu23 / Prev13:	_____	_____
Flumist:	_____	_____	Other:	_____	_____
Other:	_____	_____	RN Signature:	_____	_____

## CLIENT CONSENT

\_\_\_\_\_  
Patient Name (Please Print)

\_\_\_\_\_  
Patient DOB

\_\_\_\_\_  
Parent Name If Minor (Please Print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### CONSENT FOR MEDICAL SERVICES

#### Immunization Services

- I have been offered copies (electronic and/or paper) of the Vaccine Information Statements for all vaccines being given today.
- I understand that vaccines are not mandatory and may be refused for religious and/or other grounds.
- I understand the benefits, risks, or complications from vaccines. (Further information about the vaccines being offered is available upon request).
- I understand that all immunization records will be entered into the IRIS (Immunization Reminder Information System). Participation in the immunization registry is voluntary. To have your records removed from IRIS, you must contact the Idaho Immunization Program.
- I have been offered a copy of SCHPD's Notice of Privacy Practices.
- I consent to receive vaccinations provided by SCPHD for myself or for this child for whom I am the parent or legal guardian.

### FINANCIAL CONSENT

- SCPHD will bill your insurance company for you, and the payment may come directly to SCPHD.
- SCPHD may not be considered an In-Network provider and therefore cannot guarantee coverage by your insurance company.
- Whether your insurance company pays or not, your account balance is your responsibility.
- Some, or perhaps all, of the services provided may be non-covered services.
- Confidentiality cannot be guaranteed with insurance billing. Your insurance provider may send information to the holder of the insurance policy (who may be your parent, guardian or spouse).

I have read the Financial Consent. I understand and agree to this policy. I also understand that I will be responsible for payment of all services. I authorize release of medical information necessary to process medical claims and authorize payment of benefits to SCPHD.

# Information about the Screening Checklist for Contraindications to Vaccines

*Are you interested in knowing why we included a certain question on the screening checklist?*

*If so, read the information below. If you want to find out even more, consult the references listed at the end.*

## 1. Have you ever had a severe reaction after receiving a vaccination (e.g., rash, hives, difficulty breathing)? [all vaccines]

History of anaphylactic reaction (see question 2) to a previous dose of vaccine or vaccine component is a contraindication for subsequent doses.<sup>1</sup> Under normal circumstances, vaccines are deferred when a precaution is present. However, situations may arise when the benefit outweighs the risk (e.g., during a community pertussis outbreak).

## 2. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder? [LAIV]

The safety of intranasal live attenuated influenza vaccine (LAIV) in people with these conditions has not been established. These conditions, including asthma in adults, should be considered precautions for the use of LAIV.

## 3. Are you sick today with a fever or diarrhea? [all vaccines]

There is no evidence that acute illness reduces vaccine efficacy or increases vaccine adverse events.<sup>1</sup> However, as a precaution with moderate or severe acute illness, all vaccines should be delayed until the illness has improved. Mild illnesses (such as upper respiratory infections or diarrhea) are NOT contraindications to vaccination. Do not withhold vaccination if a person is taking antibiotics.

## 4. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? [LAIV, MMR, VAR, ZOS]

Live virus vaccines (e.g., LAIV, measles-mumps-rubella [MMR], varicella [VAR], zoster [ZOS]) are usually contraindicated in immunocompromised people. However, there are exceptions. For example, MMR vaccine is recommended and varicella vaccine should be considered for adults with CD4+ T-lymphocyte counts of greater than or equal to 200 cells/ $\mu$ L. Immunosuppressed people should not receive LAIV. For details, consult the ACIP recommendations.<sup>4,5,6</sup>

## 5. In the past 3 months, have you taken medications that affect your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments? [LAIV, MMR, VAR, ZOS]

Live virus vaccines (e.g., LAIV, MMR, VAR, ZOS) should be postponed until after chemotherapy or long-term high-dose steroid therapy has ended. For details and length of time to postpone, consult the ACIP statement.<sup>1,5</sup> Some immune mediator and immune modulator drugs (especially the antitumor-necrosis factor agents adalimumab, infliximab, and etanercept) may be immunosuppressive. The use of live vaccines should be avoided in persons taking these drugs (MMWR 2011;60 [RR-2]:23). To find specific vaccination schedules for stem cell transplant (bone marrow transplant) patients, see reference 7. LAIV can be given only to healthy non-pregnant people ages 2 through 49 years.

## 6. Do you have allergies to medications, food, a vaccine component, or latex? [all vaccines]

An anaphylactic reaction to latex is a contraindication to vaccines that contain latex as a component or as part of the packaging (e.g., vial stoppers, prefilled syringe plungers, prefilled syringe caps). If a person has anaphylaxis after eating gelatin, do not administer vaccines containing gelatin. A local reaction to a prior vaccine dose or vaccine component, including latex, is not a contraindication to a subsequent dose or vaccine containing that component. For information on vaccines supplied in vials or syringes containing latex, see reference 2; for an extensive list of vaccine components, see reference 3.

People with egg allergy of any severity can receive any recommended influenza vaccine (i.e., any IIV or RIV) that is otherwise appropriate for the patient's age. For people with a history of severe allergic reaction to egg involving any symptom other than hives (e.g., angioedema, respiratory

distress), or who required epinephrine or another emergency medical intervention, the vaccine should be administered in a medical setting, such as a clinic, health department, or physician office. Vaccine administration should be supervised by a healthcare provider who is able to recognize and manage severe allergic conditions.<sup>4</sup>

## 7. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? [LAIV, MMR, VAR, ZOS]

Certain live virus vaccines (e.g., LAIV, MMR, VAR, ZOS) may need to be deferred, depending on several variables. Consult the most current ACIP recommendations for current information on intervals between antiviral drugs, immune globulin or blood product administration and live virus vaccines.<sup>1</sup>

## 8. For women: Are you pregnant or is there a chance you could become pregnant during the next month? [HPV, IPV, MMR, LAIV, VAR, ZOS]

Live virus vaccines (e.g., MMR, VAR, ZOS, LAIV) are contraindicated one month before and during pregnancy because of the theoretical risk of virus transmission to the fetus. Sexually active women in their childbearing years who receive live virus vaccines should be instructed to practice careful contraception for one month following receipt of the vaccine. On theoretical grounds, inactivated poliovirus vaccine should not be given during pregnancy; however, it may be given if risk of exposure is imminent and immediate protection is needed (e.g., travel to endemic areas). Inactivated influenza vaccine and Tdap are both recommended during pregnancy. Both vaccines may be given at any time during pregnancy but the preferred time for Tdap administration is at 27–36 weeks' gestation. HPV vaccine is not recommended during pregnancy.<sup>1,4,5,6,8,9</sup>

## 9. Have you had a seizure or a brain or other nervous system problem? [influenza, Td/Tdap]

Tdap is contraindicated in people who have a history of encephalopathy within 7 days following DTP/DTaP given before age 7 years. An unstable progressive neurologic problem is a precaution to the use of Tdap. For people with stable neurologic disorders (including seizures) unrelated to vaccination, or for people with a family history of seizure, vaccinate as usual. A history of Guillain-Barré syndrome (GBS) is a consideration with the following: 1) Td/Tdap: if GBS has occurred within 6 weeks of a tetanus-containing vaccine and decision is made to continue vaccination, give Tdap instead of Td if no history of prior Tdap; 2) Influenza vaccine (IIV/LAIV): if GBS has occurred within 6 weeks of a prior influenza vaccine, vaccinate with IIV if at increased risk for severe influenza complications.

## REFERENCES

1. CDC. General recommendations on immunization, at [www.cdc.gov/mmwr/pdf/rr/r6002.pdf](http://www.cdc.gov/mmwr/pdf/rr/r6002.pdf).
2. Latex in Vaccine Packaging: [www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/latex-table.pdf](http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/latex-table.pdf).
3. Table of Vaccine Components: [www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/recipient-table-2.pdf](http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/recipient-table-2.pdf).
4. CDC. Prevention and control of seasonal influenza with vaccines: Recommendations of the Advisory Committee on Immunization Practices – United States, 2016–17 influenza season at [www.cdc.gov/mmwr/volumes/pdf/65/rr/pdfs/r6505.pdf](http://www.cdc.gov/mmwr/volumes/pdf/65/rr/pdfs/r6505.pdf), pages 1–56.
5. CDC. Measles, mumps, and rubella – vaccine use and strategies for elimination of measles, rubella, and congenital rubella syndrome and control of mumps. MMWR 1998; 47 (RR-8).
6. CDC. Prevention of varicella: Recommendations of the Advisory Committee on Immunization Practices. MMWR 2007; 56 (RR-4).
7. Tomblyn M, Einsele H, et al. Guidelines for preventing infectious complications among hematopoietic stem cell transplant recipients: a global perspective. Biol Blood Marrow Transplant 15:1143–1238; 2009 at [www.cdc.gov/vaccines/pubs/hemato-cell-transpts.htm](http://www.cdc.gov/vaccines/pubs/hemato-cell-transpts.htm).
8. CDC. Notice to readers: Revised ACIP recommendation for avoiding pregnancy after receiving a rubella-containing vaccine. MMWR 2001; 50 (49).
9. CDC. Updated recommendations for use of tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis vaccine (Tdap) in pregnant women: Recommendations of the ACIP. MMWR 2012; 62 (7):131–4.

Adapted from the **Immunization Action Coalition** · Saint Paul, Minnesota · 651-647-9009 · [www.immunize.org](http://www.immunize.org)