

Durham County Health Department FluMist Vaccination Program- 2009

Please complete this form if you wish for your child to receive free FluMist at school on _____.

This form **MUST** be returned to your child's teacher by **October 2, 2009**.

***** DO NOT return this form if you do not want your child to receive the FluMist Vaccine. *****

Child's Information:

Name: _____ **Grade:** _____
Last Name First Name MI

School Name: _____ **Teacher Name:** _____

Date of Birth: _____ / _____ / _____ **Age:** _____ **Male** **Female**
Month Day Year

Home Address: _____, NC _____
Street Address City Zip Code

Parent/Guardian Contact Information:

Mother/Guardian Name	() -	() -
	<small>Home Phone Number</small>	<small>Work/Mobile Phone Number</small>
Father/Guardian Name	() -	() -
	<small>Home Phone Number</small>	<small>Work/Mobile Phone Number</small>
Emergency Contact Name	() -	() -
	<small>Home Phone Number</small>	<small>Work/Mobile Phone Number</small>

Please circle "Yes" or "No" for each of the following questions. All questions MUST be answered for your child to be eligible to receive FluMist. If you need clarification or more information about a question, you can contact Clementine Buford at the Durham County Health Department at 560-7835.

My child has received the MMR or varicella (chickenpox) vaccine in the past four (4) weeks.	Yes	No
My child has had a life-threatening reaction to FLU vaccine in the past.	Yes	No
My child has a severe allergy (hives or trouble breathing) to eggs, gentamicin, gelatin, MSG or arginine (all contained in the flu vaccine).	Yes	No
My child is currently receiving long-term aspirin treatment.	Yes	No
My child has a history of Guillain-Barré Syndrome.	Yes	No
My child has a disease such as cancer, lupus, or HIV/AIDS or takes medication such as steroids or chemotherapy that lowers the body's resistance to infection.	Yes	No
My child has a health concern such as chronic heart disease, lung disease, kidney disease, liver disease, muscle or nerve disease (such as seizures), diabetes, blood disease (such as sickle cell anemia), or may be pregnant.	Yes	No
My child frequently visits someone who has a severely weakened immune system such as a person who has had a bone marrow transplant AND CURRENTLY is in a negative pressure room in the hospital OR is currently in the hospital on chemotherapy.	Yes	No
My child has received a FLU vaccine this fall (2009).	Yes	No
My child has been diagnosed with asthma OR is less than five (5) years of age and has had multiple episodes of wheezing, or had a wheezing episode in the last twelve (12) months.	Yes	No

We will forward your child's FluMist immunization record home with your child.

My Child is: (Please check all that apply)

- American Indian or Alaskan Native
- Has Medicaid **Recipient I.D. number** _____ - _____ - _____
- Has no Medical Insurance
- Has medical insurance but it does not cover immunizations

Yes, I give permission for my child, _____, **Print child's name here**

to receive FluMist (nasal spray) at school. This vaccine is provided at no cost. I understand that if my child is under nine (9) years of age and has never had flu vaccine before he/she should receive a second dose one (1) month later during the flu season. I have read the Vaccine Information Statement for the LAIV (**FluMist**) and have had my questions answered by my child's doctor or the Durham County Health Department. I understand that I have the opportunity to review the Durham County Public Health's *Notice of Privacy Practices* by contacting the school nurse or the Durham County Health Department by calling 919-560-7835 and requesting a copy.

Parent/Guardian Signature

Date

Please return this completed form to your child's teacher by **October 2, 2009** so your child can participate in the FluMist School-Site Immunization Project.

DO NOT return this form if you do not want your child to receive the FluMist vaccine.*

We encourage you to contact your private doctor or the Durham County Health Department for flu vaccine.

For Local Health Department use Only:

Date	Type of Vaccine	Route	Mfr Lot #	Date of VIS	Nurse Signature
	FluMist	Intranasal			

Eligible child was not able to be vaccinated today due to: Illness Uncooperative Absent Other