Emergency Medical Services

LIVE, INTRANASAL INFLUENZA VACCINE ADMINISTRATION RECORD

The Emergency Medical Services agency will keep a copy of this record in their office. They will record what vaccine was given, when the vaccine was given, the name of the company that made the vaccine, the vaccine's special lot number and the signature and title of the person who gave the vaccine.

I have read and received a copy of the Vaccine Information Statement (VIS) [dated 8/11/09—Seasonal Influenza or 10/2/09—H1N1] about the Influenza Vaccine I have had an opportunity to ask questions and understand the risks and benefits of the Influenza Vaccine. I request that the vaccine be given to me according to the recommended guidelines.

PRECAUTIONS: TO THE BEST OF YOUR KNOWLEDGE:	**Yes**	**No**
Have you ever had a serious allergic reaction to a previous dose of the Influenza vaccine?		
Have you ever had an allergic reaction to egg, egg products, gentamicin, gelatin, or arginine?		
Do you have a fever (101.5F) or an acute illness more severe than a common cold or mild vomiting/diarrhea today?		
Are you more than 49 years of age? (or is the one receiving vaccine less than 2 years of age?)		
Are you immune compromised or do you anticipate being in regular close contact with someone with a severely compromised immune system within the next 7 days?		
Do you have a past history of Guillian-Barre syndrome? Do you have an active neurologic disorder?		
Do you have asthma?		
Are you pregnant?		
Do you have a long term medical condition such as heart disease, kidney disease, or diabetes?		
Are you under 18 and taking aspirin?		

INFORMATION ABOUT PERSON TO RECEIVE VACCINE *(PLEASE PRINT):*	
Name: Last First	Date of Birth:
Telephone number you can be reached at:	Dept/Location:

Signature of person to receive vaccine: _____Date_____

If person named above is less than 18 years old: I give consent for my child named above to be vaccinated with this vaccine.

Signature of Parent/Legal Guardian_____Date_____

========== **FOR EMS AGENCY USE** ==========

EMERGENCY MEDICAL SERVICES		
Date Vaccinated:	Manufacturer: ☐ ☐	Lot #:
Site of Administration: Intranasal	Name and Title of Vaccinator Printed:	Vaccinator signature: