



Pharmacy

Live, Intra **NASAL** INFLUENZA Immunization CONSENT FORM

Name (as it appears on Medicare card, if applicable): **FIRST:** _____ **MIDDLE INITIAL:** _____

LAST: _____ **SUFFIX (Jr., Sr., etc.)** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PHONE: () _____ - _____ **Date of Birth:** ____/____/____ **Sex (circle one):** M F

PAYMENT TYPE: Cash/ Check

Kroger Employee: ID# _____ **Management** (use RX card) **non-Management**(use SSN)

Other insurance: ID# _____ TP Code: _____ Group: _____ Person Code: _____

PRECAUTIONS and CONTRAINDICATIONS

1. Are you between the ages of 2 years of age and 49 years of age? 1. _____ age of patient
A prescription is necessary to administer this vaccine if patient is <9 y.o. in KY, and <14 y.o. in IN and TN)
2. For women: Are you pregnant or could become pregnant in the next month? 2. Yes _____ No _____
(If yes, patient is **NOT** eligible to receive this vaccine)
3. Do you have a fever or are you sick today? 3. Yes _____ No _____
4. Do you have heart disease, lung disease, asthma, kidney disease, any metabolic disease 4. Yes _____ No _____
(e.g.diabetes), anemia, or other immune system disorders?
5. Do you or anyone you are in contact with have a weakened immune system due to a disease 5. Yes _____ No _____
(leukemia/ lymphoma of any type, cancer(s), or HIV/AIDS), a medicine (high -dose steroids),
or any other immune system disorder?
6. Have you ever had a serious reaction to any vaccine? 6. Yes _____ No _____
7. Are you allergic to eggs, gentamicin, arginine, gelatin, or any other vaccine ingredients? 7. Yes _____ No _____
8. Do you have a history of Guillain - Barré Syndrome or an active neurological disorder? 8. Yes _____ No _____
9. Have you received any other vaccinations in the past 4 weeks? 9. Yes _____ No _____
10. Are you currently on any medication therapy (i.e. aspirin, aspirin containing therapy. 10. Yes _____ No _____
or antiviral therapy like Tamiflu or Relenza)?

CONSENT FOR SERVICE: I certify that I am at least 18 years old and hereby give my consent to the staff of Kroger Pharmacy to administer the vaccine(s) indicated below. I have read the Vaccine Information Sheets(s) (VIS) for my vaccine and understand the benefits and risks of the vaccine and choose to assume that risk. As with all medical treatment, there is no guarantee that I will not experience an adverse side effect from the vaccine(s). I fully release and discharge the standing order physician, and Kroger Limited Partnership I, dba Kroger Pharmacy, its affiliates and their officers, directors, and employees from any liability for illness, injury, loss, or damage which may result there from. I acknowledge that I have received a copy of the Kroger Company privacy policies, in accordance with HIPAA. I acknowledge that I am in a high-risk group as defined by the CDC. (Applicable only when mandated by the CDC).

* I agree to wait near the vaccination area for approximately 20 minutes to receive treatment in case of an adverse reaction.

SIGNATURE (or signature of guardian if under 18) _____

*****FOR PHARMACY USE ONLY*****

VIS: 07/26/2011

LIVE, IntraNASAL Influenza Vaccine 0.2 ml
FluMist® Medimmune

LOT # EXP. DATE

Immunizer _____ PharmD/ RPh/Student Date: _____

*****Place prescription back tag on the back of this document or store stamp with address*****



Information Screening Questions for Intranasal Influenza Vaccination

1. Are you sick today?

There is no evidence that acute illness reduces vaccine efficacy or increases vaccine adverse events. Persons with an acute febrile illness usually should not be vaccinated until their symptoms have improved. Minor illnesses with or without fever do not contraindicate use of influenza vaccine. Do not withhold vaccination if a person is taking antibiotics.

2. Do you have an allergy to eggs or to a component of the influenza vaccine?

History of anaphylactic reaction such as hives, wheezing, or difficulty breathing, or circulatory collapse or shock (not fainting) after eating eggs or receiving any component of the intranasal live attenuated influenza vaccine (LAIV, trade name FluMist®) is usually a contraindication for further doses. Check the package insert for a list of the vaccine components (i.e., excipients and culture media) used in the production of the vaccine, or go to www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/b/excipient-table-2.pdf.

3. Have you ever had a serious reaction to intranasal influenza vaccine in the past?

Patients reporting a serious reaction to a previous dose of LAIV should be asked to describe their symptoms. Immediate presumably allergic reactions are usually a contraindication to further vaccination with LAIV.

4. Is the person to be vaccinated younger than age 2 years or older than age 49 years?

LAIV is not licensed for use in persons younger than age 2 years or older than age 49 years. Based on state laws, Kroger may require a prescription for pediatric patients.

5. 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 disorders?

Persons with any of these health conditions should **not** be given the LAIV, but should receive the injectable influenza vaccine instead.

6. Do you have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as steroids, or cancer treatment with x-rays or drugs?

Persons with weakened immune systems should **not** be given the LAIV, but should receive the injectable influenza vaccine instead.

7. Are you taking aspirin therapy or aspirin-containing therapy?

Because of the theoretical risk of Reye's syndrome, children and teens on aspirin therapy should not be given LAIV. Instead they should be vaccinated with the injectable influenza vaccine.

8. Are you pregnant or could you become pregnant within the next month?

Pregnant women or women planning to become pregnant within a month should not be given LAIV. All pregnant women should, however, be vaccinated with the injectable influenza vaccine.

9. Have you ever had Guillain-Barré syndrome?

Persons with a history of Guillain-Barré syndrome (GBS) should not be given LAIV. Although data are limited, the established benefits of influenza vaccination with injectable influenza vaccine for the majority of persons who have a history of GBS, and who are at high risk for severe complications from influenza, justify yearly vaccination with the injectable influenza vaccine.

10. Do you live with or expect to have close contact with a person whose immune system is severely compromised and who must be in a protective environment?

Injectable influenza vaccine is preferred for persons who have close contact with severely immunosuppressed persons during periods in which the immunosuppressed person requires care in a protective environment.

11. Have you received any other vaccinations in the past 4 weeks?

Persons who were given an injectable live virus vaccine (e.g., MMR, MMRV, varicella, yellow fever) in the past 4 weeks should wait 28 days before receiving LAIV. There is no reason to defer giving LAIV if they were vaccinated with an inactivated vaccine or if they have recently received blood or other antibody-containing blood products (e.g., IG).

*******Place prescription back tag on the back of this document or store stamp with address*******