SHARP Rees-Stealy Medical Centers

FLU MIST ADMINISTRATION FORM 2020-2021

Patients Name: _____

Health Plan: _____

Primary Physician: _____

Medical Record #: _____

(Or place patients label here)

FOR PATIENTS OR PARENTS

Please answer following questions:

The following questions will help determine if the person is an appropriate candidate for FluMist

1. Have you received the flu vaccine before? ☐ YES ☐ NO ☐ NOT SURE

2. Do any of the following apply to the person being vaccinated with FluMist? ☐ YES ☐ NO

(If your answer is YES, the person to be vaccinated cannot receive FluMist.)

- Has been ill in the last 24 hours with temperature greater than 100.6
- Allergy gentamicin, gelatin, or arginine
- Life-threatening reactions to influenza vaccine in the past
- Is between 2 years and 17 years, and currently receiving aspirin or aspirin-containing therapy
- Is under 2 years of age

3. Do any of the following apply to the person being vaccinated? ☐ YES ☐ NO

(If your answer is YES, please determine whether the person to be vaccinated can receive FluMist.)

- Has asthma?
- Has your healthcare provider told you in the past 12 months that your child (2 yrs to 5 yrs) has wheezing or asthma?
- Experienced Guillain-Barré syndrome within 6 weeks following any prior influenza vaccination?
- Has long-term health problems with weakened immune system or heart, lung, liver, kidney, or metabolic disease (e.g., diabetes), or blood disorders?
- Is pregnant or nursing?

4. Does the person to be vaccinated expect to have close contact within the next 7 days with a person whose immune system is so severely compromised to the degree that he/she must be in a protective environment, such as a negative-pressure hospital room?

☐ YES ☐ NO

(If your answer is YES, the person to be vaccinated cannot receive FluMist.)

_____ _____

Patient or Parent/Guardian's Signature Date

CPT CODE	ADMIN CODES	MD/APP Signature	Clinical staff signature & title
90672M Flumist Nasal 2yrs-17yrs	**90473**		
Lot #: _____ Manufacturer: _____ Expiration date: _____			

MD Verified Medication ☐

Staff Use Only: Immunization history entered in EHR ☐ **Charges entered in EHR** ☐