WPG STANDING ORDER SHEET FOR FLUMIST ADMINISTRATION (2018-2019)

*****PLEASE NOTE: The providers at Willows Pediatrics recommend the INJECTABLE FLU VACCINE as the best option for your child. Flumist should be reserved as a last resort for those who would otherwise not receive any vaccine at all. Please see our website for further information.**

Patient Name:_____ DOB:_____ Age Today:_____
(one sheet per child) First Last (year and mth)

Has your child ever had a flu shot or flumist ? YES / NO

Guarantor Name:_____
(Adult's name who holds the insurance coverage)

Primary Provider in Office:_____

****If someone other than a Parent/Guardian is bringing a child in for the flumist, a written note giving permission to give the vaccine signed by a parent is required****

Criteria for eligibility to receive the Nasal Flumist Vaccine in our walk in clinic*:

1. Must be a healthy child/adolescent
2. Not presently acutely ill
3. Must be 2 years or older
4. No history of acute episodes of wheezing or asthma in the last 12 months
5. No history of any chronic illnesses or long term health problems
6. Not receiving aspirin therapy
7. No history of egg allergy
8. No history of severe reaction to influenza in the past
9. No nasal condition serious enough to make breathing difficult (extremely stuffy nose)
10. No history of Guillain-Barre Syndrome
11. No exposure or possible close contact with anyone having a weakened immune system, such as a transplant recipient, someone on chemotherapy who has decreased blood counts requiring a protective environment

Has your child received ANY vaccines within the last 4 weeks? If yes please note: _____
(if received MMR or Varicella there must be a 4 week interval before administration of Flumist)

(*Provider may allow administration of Flumist during regular office hours to patients outside of above criteria)

YOU MUST BE A PATIENT OF WILLOWS AND HAVE BEEN SEEN IN THE OFFICE.
YOU MUST SHOW A VALID INSURANCE CARD OR BE PREPARED TO PAY AT TIME OF SERVICE.

************************Below to be signed at time of service when in office************************

PARENT/PATIENT please sign below that you have read the above, been given the Vaccine Information Statement and have none of the reasons listed for NOT getting FLUMIST today. You give Willows Pediatric Group permission to administer the nasal flumist vaccine.

Criteria needed for second dose: *please check our website for criteria regarding need for second immunization.*

_____ _____ _____
Signature Relation to Patient Date

Flumist Administration Information:
Manufacturer: Medimune

Given By: _____