CONSENT FOR TREATMENT NASAL SPRAY INFLUENZA VACCINE

FluMist is available to *healthy* individuals ages 4 - 49 years who are *not* pregnant

✓ Please make checks payable to Front Range Flu Shots, LLC *or* FRFS.

Please Print

Last Name **First Name** **Middle Initial**

Date of Birth	MM	DD	YY	Age	☐ Male ☐ Female	Phone Number ( )

Address: Street **City** **State** **Zip**

Insurance Billing:

✓ Print Name *exactly* as it appears on insurance card:______________________________

☐ Douglas County School District CIGNA Member Id # 779 ___ ___ ___ ___ ___ ___ ___ ___ ___

☐ Rocky Mountain Health Plans Member Id # ___ ___ ___ ___ ___ ___ ___ ___ ___ - ___ ___

Please answer each of the following questions:

1. How old are you? ________
2. Have you ever had an influenza (flu) immunization before? ....Yes No
3. Have you received any vaccines within the last month or do you plan to receive any within the next month? ....Yes No
4. Are you in close contact with severely immunocompromised individuals requiring a protective environment (such as bone marrow transplant recipients)? ....Yes No
5. Are you pregnant or nursing? ....Yes No

Review each item below and circle Yes or No (Y or N) to indicate if you have ever had any of the following:

Allergies or Hypersensitivity to:

Chicken eggs/egg proteins ....Y N
Previous dose of flu vaccine ....Y N
Another vaccine component ....Y N
Gentamicin........Y N
Gelatin ....Y N
Arginine........Y N
MSG........Y N

Medical Conditions

Have you ever had Guillain-Barré syndrome (a serious paralytic disease, also called GBS)........Y N
Are you under 18 and on long-term aspirin treatment ....Y N

Medical Conditions (cont.)

Currently have a moderate or severe acute illness with or without fever . Y N
Asthma ....Y N
Reactive airway disease ....Y N
One or more episodes of wheezing within the past year ....Y N
Nasal condition serious enough to make breathing difficult ....Y N
A very stuffy nose........Y N
Weakened immune system ....Y N
Currently taking medications that can weaken your immune system.. Y N

Medical Conditions (cont.)

Long-term health problem(s) ....Y N
Heart disease........Y N
Lung disease ....Y N
Kidney or liver disease........Y N
Metabolic disease ....Y N
Diabetes........Y N
Anemia or other blood disorder .... Y N
Muscle or nerve disorder that can lead to breathing or swallowing problems Y N
Seizure disorder ....Y N
Cerebral palsy ....Y N
Weakened immune system………..Y N

Explain any Yes (Y) answers: ______________________________

★ I have received the *FluMist (Influenza Virus Vaccine Live, Intranasal) Information Sheet*. I have read or have had explained to me the information. I have had an opportunity to review *FRFS's Notice of Privacy Practices* and am aware that I can request a copy. I have had a chance to ask questions and, if any, they were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and I ask that the vaccine be given to me or to the person named for whom I am authorized to make this request. I agree that Front Range Flu Shots, LLC shall have no responsibility or liability if I or the named person contract influenza or any other respiratory diseases or suffer any adverse reaction following administration of the vaccine.

★ I understand that I am responsible for payment to Front Range Flu Shots, LLC if vaccination is not fully covered by insurance company.

★ I understand there is a $25 fee for returned checks.

Signature of Responsible Person: ______________________ *Date*: ____________

Insurance Coding Information	
Federal Tax ID:	743077363
Service Location:	11
Diagnosis Code:	V04.81
Procedure Code:	90660
Administration Code:	90473
RMHP Administration Code:	90471
Charge:	$
Clinic Location:	

Do not write below this line.

NASAL SPRAY INFLUENZA VACCINE

Nurse's Initials	
Date	
Mfg	MedImmune
Lot #	

Please remit to: Front Range Flu Shots, LLC ▲ P.O. Box 1093, Littleton, CO 80160-1093 ▲ 303-797-3396 08-10

DCSD / RMHP / Invoice / Check _____ / Cash _____