

**WPG STANDING ORDER SHEET FOR FLUMIST ADMINISTRATION (2011-2012)**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age Today: \_\_\_\_\_  
(one sheet per child) First Last

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 flu vaccine a written note giving permission to give the vaccine signed by a parent will be required to allow for administration.\*\*\*

Criteria for eligibility to receive the Nasal FluMist Vaccine:

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 severe 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 etc.

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)

**YOU MUST BE A PATIENT OF WILLOWS AND 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 contraindications to not getting FLUMIST. Therefore 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: Medimmune Lot # 501086P Exp: 20 Nov 2011

Given By: \_\_\_\_\_