Before you get FluMist® today…

Please fill out **one form** for each person in your family who wants FluMist® today.
Parents: Please answer for your child.

Name: ______________________________ Date of birth: ______________________

1.	Are you sick today?	☐ Yes	☐ No	
2.	Are you allergic to eggs or any other ingredient in FluMist®?	☐ Yes	☐ No	☐ Don't know
3.	Have you ever had a serious reaction to a flu vaccine?	☐ Yes	☐ No	☐ Don't know
4.	Have you ever had Guillain-Barré Syndrome?	☐ Yes	☐ No	☐ Don't know
5.	Do you have any long-term health problems, such as diabetes, anemia, asthma, a blood disorder, or heart, lung, or kidney disease?	☐ Yes	☐ No	☐ Don't know
6.	Is your immune system weak because of HIV/AIDS, steroid treatment, cancer treatment with x-rays or drugs, or other autoimmune disease?	☐ Yes	☐ No	☐ Don't know
7.	Do you have close contact with someone getting treatment for a severely weak immune system?	☐ Yes	☐ No	☐ Don't know
8.	Are you taking aspirin or other medicine that contains aspirin?	☐ Yes	☐ No	☐ Don't know
9.	Did you get any other vaccines in the last 4 weeks?	☐ Yes	☐ No	☐ Don't know
10.	Are you pregnant or could you be pregnant in the next month? (Pregnant women should get the flu vaccine instead of FluMist®.)	☐ Yes	☐ No	☐ Don't know
11.	*For children 2-4 years old:* Any wheezing or asthma in the last year?	☐ Yes	☐ No	☐ Don't know

If you answer *Yes*, we will ask you more questions before you get FluMist®.

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