2010 H1N1 Influenza Vaccine Consent Form

Section 1: Information Needed to Receive Vaccine (please print)

NAME (Last)	(First)	(M.I.)	**DATE OF BIRTH** **Month _____ day _____ year _____**
ADDRESS			**AGE** / **GENDER** **Male / Female**
CITY / **STATE**	**ZIP** / **COUNTY**		**DAYTIME PHONE NUMBER:**
PHYSICIAN	**PARENT/LEGAL GUARDIAN'S NAME** (Last)	(First)	(M.I.)

Section 2: Screening for Vaccine Eligibility. Indicate which priority group you belong to. (Mark all that apply)

_____Pregnant _____Health care or EMS
_____Age 6 months - 24 years _____Healthy Person 25-64 years _____Persons > 64 years
_____Live with or provide care for infant aged<6 months (e.g., parents, siblings, and daycare providers)
_____Person 25-64 years with high risk medical conditions

The following questions will help us to know if you can get the 2009 H1N1 influenza vaccine. Please mark YES or NO for each question.

A. Assessment of Influenza Immunization Status.	**YES**	**NO**
1. Have you gotten vaccinated with any vaccine (not just flu) within the past 30 days? Vaccine: _____ Date given: month_____day_____year_____		
2. Do you have a Latex allergy?		
3. Are you pregnant?		
4. Do you have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood?		
5. Are you on long-term aspirin or aspirin-containing therapy (for example, do you take aspirin every day)?		
6. Do you have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)?		
7. Do you have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?		

B. Assessment for Contraindications to H1N1 Vaccine.	**YES**	**NO**
1. Have you ever had a serious reaction to a previous dose of flu vaccine?		
2. Do you have an allergy to eggs or egg products, chicken or chicken feathers, thimerosal containing products (eye contact lens solution) or mercury containing products?		
3. Have you ever had Guillain-Barré Syndrome?		

Section 3: Consent For Vaccination:

I have read the vaccine information statement or have had the information explained to me. I have had a chance to ask questions and these have been answered to my satisfaction. I understand the benefits and risks of this vaccine and ask that the vaccine be given to me , or to the person named above for whom I am authorize to make this request. I accept responsibility for seeking medical attention for any problems with this vaccination.

Signature: _____ Date: _____

Section 4: Vaccination Record **FOR ADMINISTRATIVE USE ONLY**

Vaccine	**Date Dose Administered**	**Route & Dose**	**Site**	**Dose Number**	**Vaccine Manufacturer**	**Lot Number Exp. Date**	**Name and Title of Vaccine Administrator**
2009 H1N1		IM .25cc .5cc Intranasal	RD LD	1st 2nd			
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