

2009 H1N1 Influenza Vaccine Consent Form

Section 1: Information to Receive Vaccine (please print)

NAME (Last)		(First)	(M.I.)	DATE OF BIRTH month day year		
ADDRESS			AGE	GENDER M / F		
CITY	STATE	ZIP		DAYTIME PHONE NUMBER		
FACILITY						

Section 2: Screening for Vaccine Eligibility

If you have already been vaccinated with 2009 H1N1 influenza vaccine, please tell us the number of doses and dates of vaccination.

- Dose 1 Date received: month ____ day ____ year ____ Form (please circle): nasal spray shot
- Dose 2 Date received: month ____ day ____ year ____ Form (please circle): nasal spray shot

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. If you answer "NO" to all four of the following questions, you can probably get the influenza vaccine. If you answer "YES" to one or more of the following four questions, you may be able to get the 2009 H1N1 vaccine, but we will contact you to discuss your options.

	YES	NO
1. Do you have a serious allergy to eggs?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have any other serious allergies? Please list: _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had a serious reaction to a previous dose of flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>

B. There are two kinds of 2009 H1N1 influenza vaccine. Your answers to the following questions will help us know which of the two kinds of vaccine you can get. If eligible which type of vaccine do you prefer? Nasal Spray or Injectable

	YES	NO
1. Have you gotten vaccinated with any vaccine (not just flu) within the past 30 days? Vaccine: _____ Date given: month ____ day ____ year ____	<input type="checkbox"/>	<input type="checkbox"/>
2. 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?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you on long-term aspirin or aspirin-containing therapy (for example, do you take aspirin every day)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
6. 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)?	<input type="checkbox"/>	<input type="checkbox"/>

Section 3: Consent

CONSENT FOR VACCINATION:

I have read or had explained to me the 2009-2010 Vaccine Information Statement for the 2009 H1N1 influenza vaccine and understand the risks and benefits.

I GIVE CONSENT to the STATE/LOCAL health department and its staff to be vaccinated with this vaccine.
(If this consent form is not signed, dated, and returned, then you will not be vaccinated)

Signature _____
Date: month ____ day ____ year ____

I DO NOT GIVE CONSENT to the STATE/LOCAL health department and its staff to be vaccinated.

Signature _____
Date: month ____ day ____ year ____

Section 4: Permission to Release Information

Placeholder for parental consent for release of data from vaccination record.

Section 5: Vaccination Record

FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Dose Administered	Route	Dose Number (1st or 2nd)	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator
2009 H1N1	/ /	<input type="checkbox"/> IM <input type="checkbox"/> Intranasal				
2009 H1N1	/ /	<input type="checkbox"/> IM				