



2009 H1N1 Influenza Vaccine Consent Form



Section 1: Information about Person to Receive Vaccine (please print)

NAME (Last)	(First)	(M.I.)	DATE OF BIRTH Month _____ Day _____ Year _____	
ADDRESS			AGE	GENDER M F
CITY/COUNTY/STATE/ZIP CODE			DAYTIME PHONE NO.:	
SCHOOL			GRADE	

Section 2: Screening for Vaccine Eligibility

If person to be vaccinated has 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

The following questions will help us to know if person to be vaccinated 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, person to be vaccinated can probably get the influenza vaccine. If you answer "YES" to one or more of the following four questions, person to be vaccinated may be able to get the 2009 H1N1 vaccine, but we will discuss your options.

	YES	NO
1. Does person to be vaccinated have a serious allergy to eggs?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does person to be vaccinated have any other serious allergies? Please list: _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Has person to be vaccinated ever had a serious reaction to a previous dose of flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has person to be vaccinated 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 person to be vaccinated can get.

	YES	NO
1. Has person to be vaccinated 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. Does person to be vaccinated 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. Is person to be vaccinated on long-term aspirin or aspirin-containing therapy (for example, does person to be vaccinated take aspirin every day)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Does person to be vaccinated 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. Is person to be vaccinated pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does person to be vaccinated 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 medical staff for the person named at the top of this form to be vaccinated with H1N1 Influenza vaccine.

Signature of Patient/Parent/Legal Guardian _____ Date: Month _____ Day _____ Year _____

Parent/Legal Guardian Printed Name _____

(please circle): Mother, Father, Self, Other _____

Section 4: Vaccination Record

FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Dose Administered	Route	Site IM	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	LD RD LT RT				
2009 H1N1	/ /	<input type="checkbox"/> IM <input type="checkbox"/> Intranasal	LD RD LT RT				