

2009 H1N1 Influenza Vaccine Consent Form

Information about person to receive vaccine (please print)

Name: _____
LAST FIRST DATE OF BIRTH AGE

Address: _____
STREET CITY ZIP CODE DAYTIME PHONE NUMBER () -

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

	YES	NO
1. Is the person receiving vaccine sick today?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the person receiving vaccine have a serious allergy to eggs?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does the person receiving vaccine have any other serious allergies that you know of? If yes, please list:	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the person receiving vaccine ever had a serious reaction to a previous dose of flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
5. Has the person receiving vaccine 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"/>
6. Has the person receiving vaccine been vaccinated with any vaccine (not just flu) within the past 30 days? Vaccine _____ Date given: _____ (m/d/yr)	<input type="checkbox"/>	<input type="checkbox"/>
7. Does the person receiving vaccine 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"/>
8. For children only: Is the child receiving vaccine on long-term aspirin or aspirin-containing therapy (for example, does your child take aspirin every day)?	<input type="checkbox"/>	<input type="checkbox"/>
9. Does the person receiving vaccine have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer), or is the person pregnant?	<input type="checkbox"/>	<input type="checkbox"/>

If the person receiving vaccine 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 injection
 Dose 2 Date received: month ____ day ____ year ____ Form (please circle): nasal spray injection

Consent for Vaccination

I have read or have had explained to me the Vaccine Information Statement (VIS) on 2009 H1N1 Influenza Vaccine. I give my consent for the person, named at the top of this form to be vaccinated with this vaccine. I understand that if I sign below I am giving consent that the person named above will be given the most appropriate vaccine as determined by the health care provider giving the vaccine.

Signature of Adult or parent/legal guardian: _____
DATE

FOR CLINICAL USE ONLY

Form reviewed by: _____ Date: _____

FOR ADMINISTRATIVE USE ONLY

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