

2009 H1N1 Influenza Vaccine Consent Form

Section 1: Information on Client to Receive Vaccine (please print)

NAME (Last)		(First)	(M.I.)	DATE OF BIRTH month _____ day _____ year _____	
AGE	GENDER M / F				
ADDRESS			DAYTIME PHONE NUMBER:		
CITY	STATE	ZIP			
County			Cell Phone #		

The following questions will help us to know if your 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 talk with you to discuss your options.

	YES	NO
2. Do you have a serious allergy to eggs?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have any other serious allergies? Please list: _____	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had a serious reaction to a previous dose of flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
5. 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.

	YES	NO
1. Are you over the age of 49?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you been vaccinated with any vaccine (not just flu) within the past 30 days? Vaccine: _____ Date given: month _____ day _____ year _____	<input type="checkbox"/>	<input type="checkbox"/>
3. 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"/>
4. Are you on long-term aspirin or aspirin-containing therapy (for example, do you take aspirin every day)?	<input type="checkbox"/>	<input type="checkbox"/>
5. 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"/>
6. Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input type="checkbox"/>	<input type="checkbox"/>

Section 2: Consent

<p>I have read or have had explained to me the 2009-2010 Vaccine Information Statement for the 2009 H1N1 influenza vaccine and have had the opportunity to ask questions, which were answered to my satisfaction. I understand the risks and benefits of this vaccine and give consent for Buffalo County Public Health and designated staff to vaccinate the individual listed at the top of this form (for whom I have authority to provide consent) with the appropriate Vaccine based on professional assessment of contraindications present. I also Consent for this information to be entered into the WI Immunization Registry.</p> <p>Print Name _____</p> <p>Signature _____</p> <p>Date: month _____ day _____ year _____</p>	<p>I GIVE CONSENT to the STATE/LOCAL health department and its staff to bill my private insurance company for an administration fee.</p> <p>Insurance Company Name: _____</p> <p>Mailing Address: _____</p> <p>Group #: _____ ID #: _____</p> <p>Signature: _____</p> <p>Date: month _____ day _____ year _____</p>
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Section 3: 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 <input type="checkbox"/> Intranasal				