

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	STATE	ZIP			

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

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.

	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 Public Health – Idaho North Central District and its staff to vaccinate me with this vaccine.

Signature: _____ Date: month _____ day _____ year _____

Section 4: (OPTIONAL) Permission to Transfer Information

I give permission to **enroll** me and to transfer my immunization records into the **Idaho Immunization Reminder Information System (IRIS)** to ensure that this vaccination record is available to me and my health care providers. I understand that I may be asked for information that will help ensure my records are accurate and will not be confused with another person's records, such as: mother's maiden name and/or gender. I authorize inclusion of all information into IRIS and re-disclosure of this information from IRIS to authorized users.

Signature: _____ Date: month _____ day _____ year _____

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 <input type="checkbox"/> Intranasal				