2009 H1N1 Influenza Vaccine Consent Form-Guthrie County Public Health Nursing

Section 1: Information Needed to Receive Vaccine (please print)

NAME (Last)	(First)	(M.I.)	**DATE OF BIRTH** **month_____ day_____ year _____**	
PARENT/LEGAL GUARDIAN'S NAME (Last)	(First)	(M.I.)	**AGE**	**GENDER** **M / F**
ADDRESS			**DAYTIME PHONE NUMBER:**	
CITY	**STATE**	**ZIP**		
PHYSICIAN				

Section 2: Screening for Vaccine Eligibility

Indicate which priority group you belong to. (Mark all that apply.)

_____Pregnant _____Live with or provide care for infant aged<6 months(e.g., parents, siblings, and daycare providers)

_____Health care or EMS _____Aged 6 months-24 years ___Healthy people age 25-64 years

_____Aged 25-64 years who have medical conditions that put me in at higher risk for influenza complications _____People over 64 years

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?	☐	☐
2. Do you have any other serious allergies? Please list: _____	☐	☐
3. Have you ever had a serious reaction to a previous dose of flu vaccine?	☐	☐
4. Have you ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	☐	☐

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

□

	YES	NO
1. Have you been vaccinated with any vaccine (not just flu) within the past 30 days? Vaccine: _____ Date given: month_____day_____year_____	☐	☐
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?	☐	☐
3. Are you on long-term aspirin or aspirin-containing therapy (for example, do you take aspirin every day)?	☐	☐
4. Do you have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)?	☐	☐
5. Are you pregnant?	☐	☐
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)?	☐	☐
7. Have you been treated with oral antiviral medication (for example: Tamiflu, Relenza, Valtrex) in the last week?	☐	☐

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 have been offered the Notice of Privacy Statement. I expressly release from any liability the above named organization and individual giving the vaccine(s).

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	/ /	☐ IM ☐ Intranasal				
2009 H1N1	/ /	☐ IM ☐ Intranasal				