

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	MALE <input type="checkbox"/>	FEMALE <input type="checkbox"/>
CITY	STATE	ZIP	DAYTIME PHONE NUMBER Home: _____ Work: _____		
SCHOOL NAME, if applicable and GRADE			CLINIC NAME/SITE		

Section 2: Screening for Vaccine Eligibility

If child has already been vaccinated with 2009 H1N1 influenza vaccine, please tell us the number of doses and dates of vaccination. (2 doses only for children 6 months through 9 years)

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

The following questions will determine if person is eligible for the 2009 H1N1 influenza vaccine. Please mark YES or NO for each question.

A. If the answer is "YES" for one or more of the following questions in this section a health care provider will discuss your options.

	YES	NO
1. Do you have a serious allergy to eggs?		
2. Do you have severe/life threatening allergies? Please list:		
3. Have you ever had a reaction to a flu shot before?		
4. If yes to the previous question, did you have a serious reaction? Describe:		
5. Have you ever had Guillain-Barré Syndrome?		

B. There are two kinds of 2009 H1N1 influenza vaccine. Your answers to the following questions will determine which vaccine you can receive.

	YES	NO
If you need more space for additional Vaccines Mark here: <input type="checkbox"/> List additional Vaccines on Back of Form		
1. Have you been vaccinated with any vaccine (including seasonal FLU) within the past 30 days? Vaccine: _____ Date given: month ___ day ___ year _____ Vaccine: _____ Date given: month ___ day ___ year _____ Vaccine: _____ Date given: month ___ day ___ year _____		
2. Do you have any of the following: auto immune disorder, asthma, diabetes, lung, heart, kidney, and/or liver disease?		
3. Are you on long-term aspirin or aspirin-containing therapy?		
4. Have you had a fever within the last 24 hours?		
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)?		

Section 3: Consent

CONSENT FOR VACCINATION:

I have been offered a copy of the "What You Need To Know" 2009 H1N1 Influenza "Vaccine Information Statement 10/2/09". I have read or have had explained to me and understand, the information in this "Vaccine Information Statement". I give consent for the person named at the top of this form to be vaccinated with H1N1 vaccine. I give my consent for information contained on this form to be released to the Kansas Countermeasure Response & Administration (KS-CRA) for the purpose of assessment and reporting. I have been offered a copy of the Notice of Privacy Practices with effective date of 4/14/2003. Notice of Privacy Practices can be found at the CK Co. Health Dept., CK Co. Schools, and on the CK Co. Health Dept. website at www.cherokeecountyks.org under Downloads.

X / _____ / _____
 Signature of Recipient/Parent/Legal Guardian Print Name Month / Day / Year

Section 4: Vaccination Record

FOR ADMINISTRATIVE USE ONLY

<input type="checkbox"/> IM H1N1 Flu Vaccine 6-35 Months 0.25ml Manufacturer Lot # Sticker <input type="checkbox"/> IM H1N1 Flu Vaccine Age 3 years and over 0.5ml	Site of IM Injection <input type="checkbox"/> Left <input type="checkbox"/> Deltoid <input type="checkbox"/> Right <input type="checkbox"/> Vastus Lateral
<input type="checkbox"/> Intranasal H1N1 Vaccine Age 2 years to 49 years Manufacturer Lot # Sticker	Signature and Title of Vaccine Administrator Date