

2009-2010 H1N1 Influenza Vaccine Consent Form

Section 1: Information to receive vaccine (please print)

NAME (Last)		(First)	(M.I.)	DATE OF BIRTH month ____ day ____ year ____	
ADDRESS				AGE	GENDER M / F
CITY	STATE	ZIP		DAYTIME PHONE NUMBER:	
PARENT/LEGAL GUARDIAN'S NAME (Last)		(First)	(M.I.)		

Section 2: Screening for Vaccine Eligibility

If your child is 9 or under and has already been vaccinated with the H1N1 vaccine, please tell us the date of vaccination: ____/____/____

The following questions will help us to know if you or your child can get the H1N1 vaccine. Please check YES or NO for each question.

	Yes	No
Do you/child have a serious allergy to eggs?		
Do you/child have any serious allergies? Please List:		
Have you/child ever had a serious reaction to any vaccine?		
Have you/child ever had Guillain-Barre Syndrome?		

The following questions will help us to know which of the two types of H1N1 vaccine you or your child can get. Please check YES or NO for each question.

	Yes	No
Have you/child been vaccinated with any vaccine with the past 30 days? Vaccine: _____ Date: ____/____/____		
Do you/child have any of the following: asthma, diabetes (or other metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood?		
Do you/child have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)?		
Are you/child pregnant?		
Do you/child have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?		
Child Only: is your child on long-term aspirin or aspirin-contained therapy (for example, does your child take aspirin every day)?		

Section 3: Consent for Vaccination

I give consent to the Lincoln County Health Department and its staff for myself or my child named at the top of this form to be vaccinated with this vaccine. If this consent form is not signed and dated, then you or your child will not be vaccinated. I have read or had explained to me the 2009 VIS for H1N1 vaccine and understand the risks and benefits. I acknowledge the receipt of the Lincoln County Health Department notice of privacy practices.

Signature of Person or Parent/Legal Guardian: _____ Date: ____/____/____

For Administrative Use Only

Vaccine	Date Given	Route	Dose #	Dose Amount	Vaccine Manufacturer	Lot Number	Name & Title of Vaccinator Administrator
2009 H1N1	____/____/____	<input type="checkbox"/> IM R / L <input type="checkbox"/> Intranasal	1st 2nd				