

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			
PARENT/LEGAL GUARDIAN'S NAME (if under 18) (Last)			(First)	(M.I.)	DAYTIME PHONE NUMBER:

Section 2: Screening for Vaccine Eligibility

If you have already been immunized with 2009 H1N1 influenza vaccine, please tell us the number of doses and dates of immunization.

- 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 pertain to the person receiving the immunization and will help us to know if you can get the 2009 H1N1 influenza vaccine. Please mark YES or NO for each question.

	YES	NO
1. Do you have a serious allergy to: <input type="checkbox"/> eggs <input type="checkbox"/> medications <input type="checkbox"/> latex <input type="checkbox"/> vaccines If yes, please explain:	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have any other serious allergies that you know of? 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"/>

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 been vaccinated with any vaccine (including seasonal 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 YOU/YOUR CHILD'S IMMUNIZATION:

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 South Central Public Health and its staff for me/my child named at the top of this form to be immunized with this vaccine.

Signature _____ Date: _____

Section 4: Permission to Release Information

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

Signature _____ Relationship to Child (if applicable) _____ Date _____

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				