IM or intranasal form

2009 H1N1 Influenza Vaccine Consent Form for Adults

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**		**DAYTIME PHONE NUMBER:**	

Section 2: Screening for Vaccine Eligibility

Have you 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
☐ I have not been vaccinated with the H1N1 influenza vaccine.

The following questions will help us to know if you can get the 2009 H1N1 influenza vaccine. Please mark YES or NO for ALL questions below.

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.

	YES	NO
1. Do you have a serious allergy to eggs or gelatin?	☐	☐
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 (injection and nasal spray). Your answers to the following questions will help us know which of the two kinds of vaccine you can get. A registered nurse will determine which kind of vaccine will be given based on answers and vaccine availability.

	YES	NO
1. Have you been vaccinated with any vaccine (including flu) within the past 30 days? Vaccine: _____________________ Please circle: *Shot / Nasal Spray* Date given: month_____day______year_______	☐	☐
2. Do you have any of the following: asthma, wheezing, use an inhaler, seizures, cerebral palsy, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, blood, nerves?	☐	☐
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)?	☐	☐
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. Are you allergic to gentamicin or amino acid arginine?	☐	☐
8. Have you taken antiviral medications in the last 48 hours?	☐	☐

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 understand that this information will be entered into a statewide online vaccine registry.

I GIVE CONSENT to the Wood County health department and its staff to be vaccinated with this vaccine.

Signature____

Date: month________day________year_____________

Section 4: Vaccination Record

FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Dose Administered	Route/Site	Dose Number (1st or 2nd)	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator
2009 H1N1		☐ IM ________ ☐ Intranasal				
2009 H1N1		☐ IM ________ ☐ Intranasal				