



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	
PARENT/LEGAL GUARDIAN'S NAME (Last)		(First)	(M.I.)	AGE	GENDER
					M / F
ADDRESS				PARENT/GUARDIAN DAYTIME PHONE NUMBER:	
CITY	STATE	ZIP			
MEDICARE #				MEDICAID #	

Section 2: Screening for Vaccine Eligibility

If your child has already been vaccinated with 2009 H1N1 influenza vaccine, please tell us the number of doses and dates of vaccination.

- | | | | | |
|---------------------------------|---|-----------------------|-------------|------|
| <input type="checkbox"/> Dose 1 | Date received: month ___ day ___ year _____ | Form (please circle): | nasal spray | shot |
| <input type="checkbox"/> Dose 2 | Date received: month ___ day ___ year _____ | Form (please circle): | nasal spray | shot |

THE FOLLOWING QUESTIONS WILL HELP US TO KNOW IF THE PERSON BEING IMMUNIZED CAN GET THE 2009 H1N1 INFLUENZA VACCINE.

PLEASE MARK YES OR NO FOR EACH QUESTION.

	YES	NO
1. Does the person being immunized have a serious allergy to eggs?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the person being immunized have any other serious allergies? Please list:	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the person being immunized ever had a serious reaction to a previous dose of flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the person being immunized ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks of receiving flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>

There are two types of 2009 H1N1 influenza vaccine. Your answers to the following questions will help us know which type the person being immunized will receive.

	YES	NO
1. Has the person being immunized been given any vaccines, including any flu vaccine within the past 30 days? Vaccine: _____ Date given: month ___ day ___ year _____	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the person being immunized have any of the following: recurrent wheezing, 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. Is the person being immunized on long-term aspirin or aspirin-containing therapy (for example, does the person being immunized take aspirin every day)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Does the person being immunized 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. Is the person being immunized pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does the person being immunized 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"/>
7. Has the person being immunized taken any influenza antiviral medications in the last week (ex. Tamiflu, Relenza)? If yes, when?	<input type="checkbox"/>	<input type="checkbox"/>
8. I authorize Washtenaw County Public Health Department to release this immunization record to the Michigan Care Improvement Registry, appropriate day care, school personnel, employer or the healthcare provider(s) as needed	<input type="checkbox"/>	<input type="checkbox"/>

Section 3: Consent

<p>I GIVE CONSENT to the STATE/LOCAL health department and its staff for the individual named at the top of this form to be vaccinated with this vaccine.</p> <p>Signature: _____</p> <p>Date: month ___ day ___ year _____</p>	<p>CONSENT FOR VACCINATION: I have read or had explained to me the Vaccine Information Statement for the 2009 H1N1 influenza vaccine and understand the risks and benefits.</p> <p>TYPE OF VACCINE REQUESTED:</p> <p>Nasal <input type="checkbox"/> Injectable <input type="checkbox"/> No Preference <input type="checkbox"/></p>
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