

H1N1 INFLUENZA INACTIVATED VACCINE SCREENING AND CONSENT FORM

PLEASE COMPLETE THE FOLLOWING INFORMATION FOR THE PERSON (*YOU OR YOUR CHILD*) RECEIVING VACCINE:

(PLEASE PRINT)

LAST _____ FIRST _____ M.I. _____ GENDER _____
BIRTH DATE _____ AGE _____ PHONE NUMBER(S): _____
ADDRESS _____ CITY _____ ZIP CODE _____
PARENT / GUARDIAN (*IF UNDER 18*) _____ PHYSICIAN _____

Y OR N DO YOU HAVE AN ALLERGY TO EGGS OR TO FLU VACCINE?

Y OR N HAVE YOU EVER HAD A SERIOUS REACTION TO FLU VACCINE IN THE PAST?

Y OR N DO YOU HAVE ANY OTHER SERIOUS ALLERGIES? _____

Y OR N HAVE YOU EVER HAD GUILLAIN-BARRE SYNDROME (GBS)? (*IF YOU DON'T KNOW WHAT THIS IS, YOU LIKELY HAVE NOT HAD IT*)

ADDITIONAL QUESTIONS FOR CHILDREN ONLY:

Y OR N IS YOUR CHILD LESS THAN 6 MONTHS OF AGE?

Y OR N HAS YOUR CHILD RECEIVED A PREVIOUS DOSE OF H1N1 VACCINE? IF SO WHEN? _____

I AM ELIGIBLE FOR H1N1 VACCINE BECAUSE I AM IN THE FOLLOWING PRIORITY GROUP:

- _____ I AM A HEALTHCARE PROVIDER OR EMERGENCY MEDICAL SERVICES WORKER
- _____ I AM PREGNANT
- _____ I LIVE WITH OR PROVIDE CARE FOR INFANTS YOUNGER THAN AGE 6 MONTHS (PARENTS, DAY CARE PROVIDERS)
- _____ I AM A CHILD OR YOUNG ADULT AGE 2 THROUGH 24 YEARS
- _____ I AM AGE 25 THROUGH 64 YEARS AND HAVE A MEDICAL CONDITION THAT PUTS ME AT HIGHER RISK FOR INFLUENZA-RELATED COMPLICATIONS (ASTHMA, DIABETES, ETC.)

I HAVE BEEN GIVEN A COPY AND HAVE READ, OR HAVE HAD EXPLAINED TO ME, THE INFORMATION CONTAINED IN THE VACCINE INFORMATION STATEMENT FOR 2009 H1N1 INFLUENZA INACTIVATED VACCINE. I HAVE HAD A CHANCE TO ASK QUESTIONS WHICH WERE ANSWERED TO MY SATISFACTION. I UNDERSTAND THE BENEFITS AND RISKS OF THIS VACCINE AND REQUEST THAT THE VACCINE BE GIVEN TO ME OR MY CHILD

SIGNATURE RECIPIENT, OR PARENT / GUARDIAN _____ **DATE** _____

FOR CLINIC USE ONLY

	Date Given	Site / Route	Manufacturer / Lot # / Exp.date	Administered By
2009 H1N1 Inactivated		/ IM		

Screening form reviewed prior to vaccination _____

VIS Date: 10/2/09