# H1N1 Influenza Vaccine Consent Form

| Last Name | First Name | MI | Date of Birth | Age |
|---|---|---|---|---|
| | | | | |

| Address | City | State | Zip Code |
|---|---|---|---|
| | | | |

**Target Population:**

___ Pregnant
___ Caregiver of children < 6 months of age
___ Healthcare/Emergency Worker
___ 25 – 64 yrs w/ chronic condition
___ Household contact of pregnant woman
___ 6 months – 24 yrs of age
___ Teachers and professional daycare providers

| | | | |
|---|---|---|---|
| 1. | Are you pregnant? | ___ Yes | ___ No |
| 2. | Are you ill or do you have a fever? (> 100º) | ___ Yes | ___ No |
| 3. | Are you allergic to eggs or gelatin? | ___ Yes | ___ No |
| 4. | Allergic to: thimerosal, gentamycin, Neosporin®, polymyxin B | ___ Yes | ___ No |
| 5. | Had a severe reaction to flu vaccine? | ___ Yes | ___ No |
| 6. | Have you had Guillian Barre Syndrome? | ___ Yes | ___ No |

**Flu Mist questions**

| | | | |
|---|---|---|---|
| 7. | Do you have asthma or lung disease? | ___ Yes | ___ No |
| 8. | More than 1 episode of wheezing in the past year? | ___ Yes | ___ No |
| 9. | Do you have heart disease? | ___ Yes | ___ No |
| 10. | Do you have diabetes/other endocrine disorders? | ___ Yes | ___ No |
| 11. | Do you have cerebral palsy, seizure disorder? | ___ Yes | ___ No |
| 12. | Do you have a history of swallowing problems? | ___ Yes | ___ No |
| 13. | Do you have a weakened immune system/CA/HIV? | ___ Yes | ___ No |
| 14. | Are you on medications that can weaken immune system? | ___ Yes | ___ No |
| 15. | If for a child, are they on long term aspirin treatment? | ___ Yes | ___ No |

**MEDICAL CONSENT:**

- I received the CDC Information on **H1N1**, and have read or had it explained to me.
- I understand the benefits and risks of **H1N1** vaccine and ask that it be given to me or the person named below for whom I am authorized to make this request.
- I understand that a booster dose is needed in 4 wks to have the best protection from the **H1N1** vaccine if less than 10 years of age.
- I have been offered a place to wait for 15 minutes following immunization.

| Signature Authorizing Consent | Print Name | Date |
|---|---|---|
| | | |

To be completed by clinical staff
**H1N1 Vaccine**:
Circle one: CSL Flumist Glaxo Novartis Sanofi Lot #_____

Expiration date: VIS Date:10/02/09

Dose amt: 0.25ml IM 0.50ml IM 0.2ml nasal Location: LD RD LT RT Nasal

Dose #: 1 2 Administered by: Print Name _____

Clinic Location: Today's Date: Signature _____