

H1N1 Influenza Vaccination Consent Form

HD01434F

Please complete and return this form (PLEASE PRINT).

Name receiving vaccination: _____ Birth date (mm/dd/yyyy): _____
 Address: _____ City: _____ State: _____ Zip Code: _____
 Home/Cell telephone: _____ Emergency contact number: _____
 If vaccine is being administered to a child under the age of 18 years:
 Parent/Legal Guardian: _____

Please circle YES or NO to all of the questions below:

1. Are you (or if completing for your child) allergic to eggs, egg proteins, or to another component of influenza vaccines, such as arginine, gelatin, gentamicin (antibiotic) neomycin (antibiotic) and polymyxin (antibiotic)?	Yes	No	
2. Have you (or if completing for your child) ever had a serious reaction to an influenza vaccine?	Yes	No	
3. Have you (or if completing for your child) ever had Guillain-Barre syndrome?	Yes	No	
4. Do you (or if completing for your child) have asthma or recurrent or active wheezing?	Yes	No	
5. Have you (or if completing for your child) received a vaccine within the past 30 days? If yes, please list name of vaccine(s): _____ Date _____	Yes	No	
6. Have you taken any antiviral medications (Tamiflu or Relenza) in the past 48 hours?	Yes	No	
7. If completing for your child under 18 years, is he/she currently receiving aspirin or aspirin containing therapy?	Yes	No	N/A
8. Do you (or if completing for your child) have any diseases (e.g., cancer, lupus, or human immunodeficiency virus [HIV] or acquired immunodeficiency syndrome [AIDS]) or take a medication (e.g., steroids or chemotherapy) that lowers the body's resistance to infection?	Yes	No	
9. Do you have any of the following health problems? If yes, please check: <input type="checkbox"/> Heart disease <input type="checkbox"/> lung disease <input type="checkbox"/> kidney disease <input type="checkbox"/> diabetes <input type="checkbox"/> other _____	Yes	No	
10. Are you pregnant or nursing?	Yes	No	
11. Do you agree that you or your child may have a paramedic administer the H1N1 influenza vaccine under the delegation of the Commonwealth's Acting Physician General?	Yes	No	

I have been given the Centers for Disease Control and Prevention Vaccine Information Statement (VIS). I have read the VIS and have no further questions at this time. I understand the risks and benefits of H1N1 influenza vaccine. I request and voluntarily consent that H1N1 influenza vaccine be given to _____ (self or name of child of whom I am the Parent/Legal Guardian), and I acknowledge that no guarantees have been made concerning the vaccine's success. I understand the possible side effects and warnings and precautions that should be taken into consideration prior to administration of the vaccine.

My preference for me or my child's influenza vaccine is the following:

- Inactivated injectable influenza vaccine (shot in the arm, shot in leg for infant) ONLY
- Live intranasal influenza vaccine (spray in the nose) ONLY
- Either injectable influenza vaccine OR live intranasal influenza vaccine

Name of self or Parent/Legal Guardian: _____ Date: _____

Signature of Parent/Legal Guardian: _____ Date: _____

For children younger than the date of their 10th birthday:

Your second dose of H1N1 vaccine should be given after this date: _____

For Staff use only:

Vaccine	Date Administered	Route	Dose Number (1 st or 2 nd)	Vaccine Manufacturer	Lot Number	Site/Dosage	Signature of Vaccinator
2009 H1N1	/ /	<input checked="" type="checkbox"/> IM <input type="checkbox"/> Intranasal		Sanofi Pasteur	UPO15AA	/ (0.5ml)	

1. Are you (or if completing for your child) allergic to eggs, egg proteins, or to another component of influenza vaccines, such as arginine, gelatin, gentamicin (antibiotic), neomycin (antibiotic) or polymyxin (antibiotic)? If yes, do not give vaccine—refer to Clinical Counseling Area for further instructions*
2. Have you (or if completing for your child) ever had a serious reaction to an influenza vaccine? If yes, do not give vaccine—refer to Clinical Counseling Area for further instructions*
3. Have you (or if completing for your child) ever had Guillain-Barre syndrome? If yes or unsure, do not give vaccine—refer to Clinical Counseling Area for further instructions*
4. Do you (or if completing for your child) have asthma or recurrent or active wheezing? If yes, do not give intranasal but may give injectable vaccine. If actively wheezing or visibly ill, refer to Clinical Counseling Area for further instructions*
5. Have you (or if completing for your child) received a vaccine within the past 30 days?
If yes, please list name of vaccine(s): _____ Date _____

If the vaccine was MMR, Varicella, Seasonal FluMist, Rotavirus, Smallpox, Yellow Fever, or Zoster, do not give intranasal but may give injectable vaccine*
6. Have you taken any antiviral medications (Tamiflu or Relenza) in the past 48 hours? If yes, do not give intranasal vaccine but may give injectable vaccine.
7. If completing for your child under 18 years, is he/she currently receiving aspirin or aspirin containing therapy?
If yes, do not give intranasal but may give injectable vaccine.
8. Do you (or if completing for your child) have any diseases (e.g., cancer, lupus, or human immunodeficiency virus [HIV] or acquired immunodeficiency syndrome [AIDS]) or take a medication (e.g., steroids or chemotherapy) that lowers the body's resistance to infection? If yes, do not give intranasal but may give injectable vaccine.
9. Do you have any of the following health problems? If yes, please check:
 Heart disease lung disease kidney disease diabetes other _____

If yes, do not give intranasal but may give injectable vaccine
10. Are you pregnant or nursing? If yes, do not give intranasal vaccine, but may give injectable vaccine.
11. The Acting Physician General of the Commonwealth has delegated to qualified paramedics the function of administering H1N1 influenza vaccine in approved vaccination clinics. Do you agree that you or your child may have a paramedic administer the H1N1 vaccine? If NO, refer client to a vaccinator who is not a paramedic.

*At the Clinical Counseling Area, it will be determined if the client needs to be referred to their primary care provider for yes answers to questions 1- 5.