H1N1 Influenza Vaccination Consent Form

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: _____ ***ARE YOU WELL TODAY? Yes No***

Please circle YES or NO to 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 gelatin, 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-Barŕe syndrome? Yes No**
4. **Do you (or if completing for your child) have asthma or recurrent or active wheezing? Yes No**
5. **If completing for your child under 18 years, is he/she currently receiving aspirin or aspirin containing therapy? Yes No N/A**
6. **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**
7. **Have you (or if completing for your child) received a vaccine within the past 30 days? Yes No**
   If yes, please list name of vaccine(s): _____Date _____
8. **Do you have any of the following health problems? If yes, please check: Yes No**
   ☐ Heart disease ☐ lung disease ☐ kidney disease ☐ diabetes ☐ other _____
9. **Are you pregnant or nursing? Yes No**
10. **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**

Please let us know if you or your child has close contact with anyone who has a weakened immune system and must be in a protective environment (eg, an individual who has had a bone marrow transplant).

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 or leg) 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:

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

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For Staff use only:

Vaccine	Date Administered	Route	Dose Number (1st or 2nd)	Vaccine Manufacturer	Lot Number	Site/Dosage	Signature of Vaccinator
2009 H1N1	/ /	□ IM □ Intranasal					
2009 H1N1	/ /	□ IM □Intranasal					