2009 H1N1 Influenza Vaccine Consent Form
VERMILION COUNTY HEALTH DEPARTMENT

Section 1: Information about Client to Receive Vaccine (please print)

CLIENT NAME (Last)	(First)	(M.I.)	**CLIENT DATE OF BIRTH** **month_____ day_____ year _____**	
PARENT/LEGAL GUARDIAN'S NAME (Last)	(First)	(M.I.)	**CLIENT AGE**	

Section 2: Screening for Vaccine Eligibility

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

Y Dose 1 Date received: month ____day____year_____ Form (please circle): nasal spray shot

Y Dose 2 Date received: month ____day____year_____ Form (please circle): nasal spray shot

The following questions will help us to know if you / child can get the 2009 H1N1 influenza vaccine. Please mark YES or NO for each question.

A. If you answer "NO" to all six of the following questions, you / child can probably get the influenza vaccine. If you answer "YES" to one or more of the following six questions, you / child may be able to get the 2009 H1N1 vaccine after a nurse talks to you.

	YES	NO
1. Is the client sick (with an illness other than a cold?)	Φ	Φ
2. Has the client had a fever of 100 degrees or greater during the last 24 hours?	Φ	Φ
3. Does the client have a serious allergy to eggs?	Φ	Φ
4. Has the client ever had a serious reaction to a previous dose of flu vaccine	Φ	Φ
5. Has the client ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	Φ	Φ
6. Does the client have any other serious allergies? Please list _____	Φ	Φ

B. There are two kinds of 2009 H1N1 influenza vaccine. Your answers to the following questions will help us know which of the two kinds of vaccine the client can get.

	YES	NO
1. Has the client been vaccinated with any vaccine including nasal mist (not just flu) within the past 30 days? Vaccine: _____ Date given: month_____day_____year_____	Φ	Φ
2. Does the client have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood?	Φ	Φ
3. Is the client on long-term aspirin or aspirin-containing therapy (for example, does your child take aspirin every day)?	Φ	Φ
4. Does the client have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)?	Φ	Φ
5. Is the client pregnant?	Φ	Φ
6. Does the client have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?	Φ	Φ

Section 3: Consent

CONSENT FOR CLIENT'S VACCINATION:

I have read or had explained to me the 2009-2010 Vaccine Information Statement for the 2009 H1N1 influenza vaccine and understand the risks and benefits.

I GIVE CONSENT TO THE STATE/LOCAL HEALTH DEPARTMENT AND ITS STAFF FOR THE PERSON NAMED AT THE TOP OF THIS FORM TO BE VACCINATED WITH THIS VACCINE.

I HEREBY ACKNOWLEDGE RECEIPT OF THE VERMILION COUNTY HEALTH DEPARTMENT'S NOTICE OF PRIVACY PRACTICE (EFFECTIVE DATE APRIL 14, 2003) ON THE DATE STATED BELOW.

Signature of Client/ Parent/Legal Guardian _____

Date: month_____day_____year_____

Section4: Vaccination Record

FOR ADMINISTRATIVE USE ONLY

Vaccine	Site	Route	Dose Number (1st or 2nd)	Initials of Vaccine Administrator	Vaccine Information Statement
2009 H1N1	RD / LD / RL / LL / N	Φ IM Φ Intranasal			2009 H1N1 LAIV 10/2/09
2009 H1N1	RD / LD / RL / LL / N	Φ IM Φ Intranasal			2009 H1N1 Inactivated 10/2/09