

Warren County Health Department - 2009 H1N1 Injectable Influenza Vaccine Consent Form

SECTION 1: INFORMATION ABOUT PERSON RECEIVING VACCINE (PLEASE PRINT)

NAME (Last)	(First)	(M.I.)	DATE OF BIRTH ____ / ____ / ____ month / day / year	AGE
MAILING ADDRESS/ Municipality			GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
CITY	STATE/ZIP		PHONE NUMBER	

SECTION 2: SCREENING FOR INJECTABLE VACCINE ELIGIBILITY*

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

If you answer "NO" to all four of the following questions, the person named above can probably get the influenza vaccine. If you answer "YES" to one or more of the following four questions, you need to consult with your physician for guidance.

	YES	NO
1. Does the person named above have a serious allergy to eggs or to a component of the vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
2. Is the person to be vaccinated sick today?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the person named above ever had a serious reaction to a previous dose of flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have the person named above ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
5. Has the person had any live attenuated vaccine in the last 28 days?	<input type="checkbox"/>	<input type="checkbox"/>
6. Are you pregnant <u>or</u> are you trying to become pregnant?	<input type="checkbox"/>	<input type="checkbox"/>

*Additional screening should be done prior to administration of the intranasal (live attenuated) influenza vaccine (see Immunization Action Coalition website at <http://www.immunize.org/catg.d/p4067.pdf>)

SECTION 3: CONSENT FOR 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/healthcare provider and associated staff to administer this vaccine to me or, if the name appearing above is a minor, to this individual as his/her parent/legal guardian. I also consent that the medical information on this form will be entered into the New Jersey Immunization Information System (NJIS). *(If this consent form is not signed, dated, and returned, then the person named above will not be vaccinated)*

Signature of Vaccinee/Parent/Legal Guardian: _____

Vaccinee/Parent/Legal Guardian (Print): _____

Date: _____

Witness to Signature: _____

FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Dose Administered	Route/Site	Staff Initial	Dose Number (1st or 2nd)	Vaccine Manufacturer	Lot Number
2009 H1N1		IM <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Arm <input type="checkbox"/> Leg				
2009 H1N1		IM <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Arm <input type="checkbox"/> Leg				