

## 2009 H1N1 Influenza Vaccine Consent Form

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

NAME (Last)		(First)	(M.I.)	DATE OF BIRTH month _____ day _____ year _____	
PARENT/LEGAL GUARDIAN'S NAME (Last)		(First)	(M.I.)	AGE	GENDER M / F
ADDRESS			DAYTIME PHONE NUMBER		
			Home: _____		
CITY	STATE	ZIP	Work: _____		
SCHOOL NAME, if applicable and GRADE			CLINIC NAME/SITE		

### Section 2: Screening for Vaccine Eligibility

If child has already been vaccinated with 2009 H1N1 influenza vaccine, please tell us the number of doses and dates of vaccination. (2 doses only for children 6 months through 9 years)

- |                                 |   |                       |             |      |
|---------------------------------|---|-----------------------|-------------|------|
| <input type="checkbox"/> Dose 1 | Date received: month _____ day _____ year _____ | Form (please circle): | nasal spray | shot |
| <input type="checkbox"/> Dose 2 | Date received: month _____ day _____ year _____ | Form (please circle): | nasal spray | shot |

The following questions will determine if person is eligible for the 2009 H1N1 influenza vaccine. Please mark YES or NO for each question.

**A. If the answer is "YES" for one or more of the following questions in this section a health care provider will discuss your options.**

	YES	NO
1. Do you have a serious allergy to eggs?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have severe/life threatening allergies? Please list: _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had a flu shot before?	<input type="checkbox"/>	<input type="checkbox"/>
4. If yes to the previous question, did you have a serious reaction? Describe: _____	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever had Guillain-Barré Syndrome?	<input type="checkbox"/>	<input type="checkbox"/>

**B. There are two kinds of 2009 H1N1 influenza vaccine. Your answers to the following questions will determine which vaccine you can receive.**

	YES	NO
1. Have you been vaccinated with any vaccine (not just flu) within the past 30 days? Vaccine: _____ Date given: month _____ day _____ year _____	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have any of the following: auto immune disorder, asthma, diabetes, lung, heart, kidney, and/or liver disease?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you on long-term aspirin or aspirin-containing therapy?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you had a fever within the last 24 hours?	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?	<input type="checkbox"/>	<input type="checkbox"/>
7. My child may receive the Nasal Mist (LAIV) vaccine.	<input type="checkbox"/>	<input type="checkbox"/>

### Section 3: Consent

#### CONSENT FOR VACCINATION:

I have been offered a copy of the H1N1 Influenza "Vaccine Information Statement". I have read or have had explained to me and understand, the information in this "Vaccine Information Statement". I give consent for the person named at the top of this form to be vaccinated with H1N1 vaccine. I give my consent for information contained on this form to be released to the Kansas Countermeasure Response & Administration (KS-CRA) for the purpose of assessment and reporting.

Signature of Recipient/Parent/Legal Guardian \_\_\_\_\_

Date \_\_\_\_\_  
*Month / Day / Year*

### Section 4: Vaccination Record

#### FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Dose Administered	Route	Dose Number (1st or 2nd)	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator
2009 H1N1	/ /	<input type="checkbox"/> IM <input type="checkbox"/> Intranasal				
2009 H1N1	/ /	<input type="checkbox"/> IM <input type="checkbox"/> Intranasal				

**ACKNOWLEDGEMENT OF  
RECEIPT OF NOTICE OF PRIVACY PRACTICES**

**I ACKNOWLEDGE THAT I HAVE BEEN OFFERED A  
COPY OF THE FRANKLIN COUNTY HEALTH  
DEPARTMENT'S NOTICE OF PRIVACY PRACTICES  
WITH THE EFFECTIVE DATE OF APRIL 14<sup>TH</sup>, 2003**

\_\_\_\_\_  
Signature of Patient/Patient Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Name of Minor Child