

## 2009 H1N1 Influenza Vaccine Consent Form

### Section 1: Consent for Vaccination

I GIVE CONSENT to the Columbia/Boone County Dept of Public Health and Human Services and its staff to vaccinate the person listed on this form with the 2009 H1N1 influenza vaccine. 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.

Authorized Signature (*client, if 18 or older, or parent/legal guardian*) \_\_\_\_\_

Today's Date: (month/day/year) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

### Section 2: Information About Person to Receive Vaccine (please print)

NAME (Last)	(First)	(M.I.)	DATE OF BIRTH month _____ day _____ year _____	
ADDRESS			AGE	GENDER M / F
CITY	STATE	ZIP	DO YOU LIVE INSIDE THE CITY LIMITS OF COLUMBIA? <input type="checkbox"/> Yes <input type="checkbox"/> No	
PARENT/LEGAL GUARDIAN'S NAME			DAYTIME PHONE NUMBER:	

### Section 3: Screening for Vaccine Eligibility

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

- Dose 1      Date received: month \_\_\_\_\_ day \_\_\_\_\_ year \_\_\_\_\_      Form (please circle):    nasal spray      shot
- Dose 2      Date received: month \_\_\_\_\_ day \_\_\_\_\_ year \_\_\_\_\_      Form (please circle):    nasal spray      shot

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

A. If you answer "NO" to all four of the following questions, you can probably get the influenza vaccine. If you answer "YES" to one or more of the following four questions, you may be able to get the 2009 H1N1 vaccine, but we 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 any other serious allergies? Please list: _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had a serious reaction to a previous dose of flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you 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. Do you have a fever or moderate illness today?	<input type="checkbox"/>	<input type="checkbox"/>

B. There are two different ways we can give the 2009 H1N1 influenza vaccine (shot and nasal spray). Your answers to the following questions will help us determine which form you are eligible to receive.

	YES	NO
1. Have you been vaccinated with any vaccine (including seasonal 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: diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves or blood?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you on long-term aspirin or aspirin-containing therapy (for example, do you take aspirin every day)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)?	<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. Do you have asthma or reactive airway disease or are you a child <5 years old with one or more episodes of wheezing within the past year?	<input type="checkbox"/>	<input type="checkbox"/>
8. Are you taking any prescription medicines to prevent or treat the flu?	<input type="checkbox"/>	<input type="checkbox"/>

### **FOR ADMINISTRATIVE USE ONLY - Section 4: Vaccination Record - FOR ADMINISTRATIVE USE ONLY**

Vaccine	Date Dose Administered	Route	Dosage	VIS Given	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator
2009 H1N1 Dose #1	/ /	<input type="checkbox"/> IM <input type="checkbox"/> RD LD RT LT <input type="checkbox"/> Intranasal	<input type="checkbox"/> 0.25 cc <input type="checkbox"/> 0.5 cc <input type="checkbox"/> 0.2 cc	<input type="checkbox"/> MIV 10/2/09 <input type="checkbox"/> LAIV 10/2/09			
2009 H1N1 Dose #2	/ /	<input type="checkbox"/> IM R L <input type="checkbox"/> RD LD RT LT <input type="checkbox"/> Intranasal	<input type="checkbox"/> 0.25 cc <input type="checkbox"/> 0.5 cc <input type="checkbox"/> 0.2 cc	<input type="checkbox"/> MIV 10/2/09 <input type="checkbox"/> LAIV 10/2/09			