

2009 H1N1 Influenza Vaccine Consent Form - Adult

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

NAME (Last)	(First)	(M.I.)	DATE OF BIRTH month____ day____ year____	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female
ADDRESS			CLINIC LOCATION	
CITY	STATE	ZIP		

Section 2: 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 know if you can get the 2009 H1N1 influenza vaccine. Please mark YES or NO for each question. If you answer “NO” to all five of the following questions, you can probably get the influenza vaccine. If you answer “YES” to one or more of the following five questions, you may be able to get the 2009 H1N1 vaccine, but we will contact you to discuss your options.

	YES	NO
1. Do you have a serious allergy to eggs?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have serious allergies to neomycin, gentamicin, thimerosal, gelatin or arginine or polymyxin B sulfate? 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. Are you receiving aspirin or aspirin-containing therapy?	<input type="checkbox"/>	<input type="checkbox"/>

Section 3: Target Group

Please place a check in the box next to the group that best describes you. Check only one box.

<input type="checkbox"/> Pregnant woman	<input type="checkbox"/> Person who lives with or provides care for infants aged < 6 month (parents, siblings, childcare provider)
<input type="checkbox"/> Healthcare and emergency medical services personnel	<input type="checkbox"/> Person aged 6 months-24 years
<input type="checkbox"/> Person aged 25-64 years with medical condition that puts you at higher risk for influenza-related complications	

Section 4: Consent

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 understand that the vaccine may contain thimerisol.

I GIVE CONSENT to the Vermont Department of Health, and staff working on its behalf, to vaccinate me with the H1N1 vaccine.

Signature of person to be vaccinated: _____

Date: month_____ day_____ year_____

Section 5: Vaccination Record

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Vaccine	Date Dose Administered	Route	Dose Number	Body Site	Lot Number	Manufacturer	Date VIS given	Name and Title of Vaccine Administrator
2009 H1N1	/ /	IM	<input type="checkbox"/> 1st	<input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> RT <input type="checkbox"/> LT				
2009 H1N1	/ /	IM	<input type="checkbox"/> 2d	<input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> RT <input type="checkbox"/> LT				