2009 H1N1 Influenza Vaccine Consent Form –Black Hawk County Health Department

Section 1: Information to Receive Vaccine (please print)

NAME (Last)	(First)	(M.I.)	**DATE OF BIRTH** **month_____ day_____ year _____**	
PARENT/LEGAL GUARDIAN'S NAME – MINOR (Last))	(First)	(M.I.)	**AGE**	**GENDER M / F**
ADDRESS			**PARENT/GUARDIAN DAYTIME PHONE NUMBER: If minor**	
CITY	**STATE**	**ZIP**		
SCHOOL NAME – If student			**GRADE – If student**	

Section 2: Screening for Vaccine Eligibility

If you 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

A. The following questions will help us to know if you can get the 2009 H1N1 influenza vaccine. Please mark YES or NO for each question.
Minor: Parent/guardian, please complete the questions regarding your child's health. Example: "Does your child have……..."

	YES	NO
1. Do you have a serious allergy to eggs?		
2. Do you have any other serious allergies? Please list: _____		
3. Have you even ever had a serious reaction to a previous dose of flu vaccine?		
4. Have you ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?		

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 you can receive.

	YES	NO
1. Have you been vaccinated with any vaccine within the past 30 days? Vaccine: _____ Date given: Month_____Day_____Year_____		
2. Do you have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood?		
3. Do you have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)?		
4. Are you pregnant?		
5. 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)?		

Section 4: Priority Population – Please circle

1. Pregnant
2. Household contacts and caregivers of persons less than 6 months of age
3. Health care and emergency services personnel- direct patient care only
4. Children 6m – 24 years
5. Persons 5-64 years with underlying risk factors: Chronic respiratory-health, liver, kidney: Diabetes. Immune Compromised

Section 5: Consent

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 children age 9 and under will receive two vaccines. This form must be signed to receive vaccine. By signing below, I acknowledge I have had the opportunity to read a copy or have received a copy of the Notice of Privacy Practices, Policy and Procedure (HIPAA).

Please note the following options and check your preference, prior to signing this consent

□ You may vaccinate my child during the school day; I do not wish to be present.

□ I wish to be present when my child is vaccinated, therefore, I will call to make an appointment to bring my child to the "after school hours" clinic.

Signature of person receiving vaccine (18 or older): _____ Date: Month_____Day____ Year_____

Signature of parent/guardian giving consent for minor:_____Date: Month_____Day____ Year_____

Section 6: Vaccination Record

FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Dose Administered	Route	Site	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator
2009 H1N1	/ /	□ IM □ Intranasal		CSL GSK Nov SanP MedImmune		
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