



Buchanan County Health Center Public Health Department

Prevent. Promote. Protect.

Public Health
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Adult Novel Influenza A (2009) H1N1 Influenza Vaccine Consent Form

Section 1: Demographics (please print)

NAME (Last)	(First)	(M.I.)	DATE OF BIRTH month _____ day _____ year _____ AGE:
PHONE NUMBER			GENDER M / F
ADDRESS			
CITY	STATE	ZIP	

Section 2: Screening for Vaccine Eligibility

Please mark YES or NO for each question.

	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"/>

There are two kinds of 2009 H1N1 influenza vaccine, nasal mist or shot. Your answers to the following questions will help us know which of the two kinds of vaccine you should get.

	YES	NO
1. Have you received FluMist, MMR (Measles, Mumps, Rubella) and/or Varicella (Chickenpox) vaccine in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
3. 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"/>

Section 3: 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 also understand the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I have certain rights and privacy regarding my protected health information. The Notice of Privacy Practice has been made available to me which explains those rights.

I GIVE CONSENT to Buchanan County Health Center and its staff to vaccinate me with this vaccine.

(If this consent form is not signed and dated, you will not be vaccinated)

Signature _____ Date: month _____ day _____ year _____

Section 4: Vaccination Record

FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Dose Administered	Route/Site	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				

Priority Group (circle one):

Pregnant

Parents and/or Caregiver of child < 6 months

Health Care Worker / EMS

6 months – 24 years of age

25 – 64 yrs with Chronic Illness