

2009 H1N1 Influenza HIGH RISK Vaccine Consent Form



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

NAME (LAST)	(FIRST)	(M. I.)	DATE OF BIRTH	
ADDRESS			AGE	GENDER M / F
CITY		HOME / CELL PHONE NUMBER:		
STATE	ZIP	WORK PHONE NUMBER:		
EMERGENCY CONTACT NAME (LAST / FIRST)		(PHONE NUMBER)		CLINIC NAME <i>STAFFORD HEALTHCARE CLINICS</i>

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

<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 help us to know 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 questions, you can get the influenza vaccine. If you answer "YES" to one or more of the following four questions, you may not 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?		
2. Do you have any other serious allergies that you know of? Please List:		
3. Have you ever had a serious reactions 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 types 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. Please mark YES or NO for each question.

	YES	NO
1. Have you been vaccinated with any vaccine (not just the flu) within the past 30 days Vaccine: _____ Date given _____ / _____ / _____		
2. Do you have any of the following: auto-immune disorder, asthma, diabetes, lung, heart, kidney and/or liver disease?		
3. Are you on long-term aspirin or aspirin-containing therapy?		
4. Have you had fever in the last 24 hours?		
5. Are you pregnant?		
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)?		

HIGH RISK CONDITION	<input type="checkbox"/> RESIDE WITH OR CARETAKER OF AGE 0 - 6 MONTH	<input type="checkbox"/> AGE 2 - 24
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> HEALTH CARE / EMERGENCY SERVICE PERSONNEL	<input type="checkbox"/> OTHER: _____
IF " YES " CHECK APPROPRIATE BOX: <input type="checkbox"/> AGE 25 - 64 WITH CHRONIC HEALTH DISORDER OR COMPROMISED IMMUNE SYSTEMS		

Section 3: Consent

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 and understand the risks and benefits. I give consent for the person named at the top of this form to be vaccinated with the H1N1 vaccine. I understand data from this record will be released for registration purposes in accordance with the requirements of the State of Louisiana and the Louisiana Immunization network for Kids statewide. (LINKS).

Signature of Recipient /Parent/Legal Guardian _____ DATE _____

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				