2009 H1N1 Influenza Vaccine Screening and Consent Form

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

PATIENT'S NAME (Last)	(First)	(M.I.)	**PATIENT'S DATE OF BIRTH** **month_____ day_____ year _____**	
PARENT/GUARDIAN'S NAME , if applicable (Last)	(First)	(M.I.)	**PATIENT'S AGE**	**PATIENT'S GENDER M / F**
ADDRESS			**DAYTIME PHONE NUMBER:**	
CITY	**STATE**	**ZIP**		

Section 2: Screening for Vaccine Eligibility

If the patient has already been vaccinated with 2009 H1N1 influenza vaccine, indicate 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 to know if the patient 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, the patient can probably get the influenza vaccine. If you answer "YES" to one or more of the following four questions, the patient may be able to get the 2009 H1N1 vaccine, but we would like discuss your options.

	YES	NO
1. Does the patient have a serious allergy to eggs?	☐	☐
2. Does the patient have any other serious allergies? Please list: _____	☐	☐
3. Has the patient ever had a serious reaction to a previous dose of flu vaccine?	☐	☐
4. Has the patient 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 to provide.

	YES	NO
1. Has the patient been vaccinated with any vaccine (not just flu) within the past 30 days? Vaccine: _____ Date given: month_____day_____year_____	☐	☐
2. Does the patient 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. Is the patient on long-term aspirin or aspirin-containing therapy (for example, does your child take aspirin every day)?	☐	☐
4. Does the patient have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)?	☐	☐
5. Is the patient pregnant?	☐	☐
6. Does the patient 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 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 GIVE CONSENT for me or my child named at the top of this form to be to be vaccinated with this vaccine.

Signature of Patient/Parent/ Guardian _____

Date: month_____day_____year_____

Section 5: Vaccination Record

FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Dose Administered	Route	Dose Number (1st or 2nd)	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator
2009 H1N1	/ /	☐ IM ☐ Intranasal				
2009 H1N1	/ /	☐ IM ☐ Intranasal				