

## Adult 2009 H1N1 Influenza Vaccine Consent Form

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

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

### Section 2: Screening for Vaccine Eligibility

If you have already been vaccinated with 2009 H1N1 influenza vaccine, please tell us the date of vaccination. Adults only need one dose of H1N1 vaccine, so you do not need to be vaccinated today. Please fill in your H1N1 vaccine history.

Dose 1      Date received: month \_\_\_\_ day \_\_\_\_ year \_\_\_\_\_      Form (please circle):    nasal spray                      shot

The following questions will help us to know if 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, you can probably get the influenza vaccine. If you answer "YES" to one or more of the following four questions, you will be able to get the 2009 H1N1 vaccine, but the nurse will discuss your options.

	YES	NO
1. Do you have a serious allergy to eggs, egg products, or thimerosal (contact Lens Solution)	<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"/>
5. Have you been sick with a fever or acute illness in the past 24-48 hours?	<input type="checkbox"/>	<input type="checkbox"/>

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 get.

	YES	NO
1. Are you over the age of 49?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you been vaccinated with any vaccine (not just flu) within the past 30 days? Vaccine: _____ Date given: _____ month ____ day ____ year _____	<input type="checkbox"/>	<input type="checkbox"/>
3. 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"/>
4. Do you have any muscle or nerve disorders (such as seizure disorders or cerebral palsy) that can lead to breathing or swallowing problems?	<input type="checkbox"/>	<input type="checkbox"/>
5. 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"/>
6. Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
7. 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 would like to receive:**  Intranasal H1N1 Vaccine (ages 2-49)     Injectable H1N1 Vaccine     Either  
I have received, read, and understand the **Novel H1N1 Vaccine Information Statement (VIS)**. I have had a chance to ask questions and discuss my concerns with a healthcare professional.

I, \_\_\_\_\_, (Please print name), consent to receive the Novel H1N1 vaccine.

Print Name

Signature

Date

**PLEASE COMPLETE THIS FORM IF YOU HAVE MEDICARE, MEDICAID OR PRIVATE INSURANCE**

**Insurance Company Name:** \_\_\_\_\_

**Insurance Telephone Number (\_\_\_\_)** \_\_\_\_\_

**Insurance Address** \_\_\_\_\_

**City** \_\_\_\_\_ **St** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Insurance Identification Number:** \_\_\_\_\_ **Group Number:** \_\_\_\_\_

**Name of Insured:** \_\_\_\_\_

**Date of Birth of Insured: Month** \_\_\_\_\_ **Day** \_\_\_\_\_ **Year** \_\_\_\_\_

**Relationship to Insured** \_\_\_\_\_ **Self** \_\_\_\_\_ **Spouse** \_\_\_\_\_ **Child** \_\_\_\_\_ **Dependent**

**I certify the information given by me is correct to the best of my ability. I authorize any holder of medical or other information about me to release the Social Security Administration or its intermediaries or carriers any information needed for this claim. I permit a copy of this authorization to be used in place of the original. I request that payment of authorized benefits be made on my behalf. I assigned the benefits payable for these services to the organization furnishing the service or authorize such physician or organization to submit a claim to Medicare for payment by me. I have also received a copy of the Notice of Privacy Practices.**

**Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

**Section 4: Vaccination Record**  
**FOR ADMINISTRATIVE USE ONLY**

Vaccine	Date Dose Administered	Route	Site	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator
2009 H1N1		<input type="checkbox"/> IM <input type="checkbox"/> Intranasal	<input type="checkbox"/> RDT <input type="checkbox"/> LDT			

VIS Date – 10/2/09

Date VIS given \_\_\_\_\_