

**2009 H1N1 INFLUENZA VACCINE CONSENT FORM FOR ADULTS**



Date: \_\_\_\_\_

Clinic Site: \_\_\_\_\_

**\*\*PLEASE PRINT CLEARLY\*\***

First Name:	Middle Name:	Last Name:
Street Address:		
City:	State:	Zip:
Date of Birth:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	Age:
<b>Patient ID # from online pre-registration:</b> (Please have your online form ready, if you have one.)	Telephone Number:	

**Please indicate which of the following priority groups best describes your current status:**

- \_\_\_\_\_ Pregnant women
- \_\_\_\_\_ Caregivers of children younger than 6 months of age
- \_\_\_\_\_ Healthcare and emergency medical service workers with direct patient contact
- \_\_\_\_\_ Adults younger than 25 years of age
- \_\_\_\_\_ Adults 25 through 64 years of age who have certain health conditions such as HIV, diabetes, heart disease or lung disease

**Please indicate that you have been given each of the following statements:**

- \_\_\_\_\_ I have received a copy of the 2009 H1N1 Vaccine Information Statement dated 10/2/09.
- \_\_\_\_\_ I have had the chance to review the Medina County Health Department's Notice of Privacy Practices which explains how my personal health information may be used.

**Please answer all of the questions on the back of the form and then sign and date the form as indicated. Please direct all medical questions to a nurse. Thank you.**

<p><b>For Staff Use Only:</b> Initials of Admin. Support Staff Reviewing Form: _____</p> <p><b>For Data Entry Use Only:</b> Initials of Data Entry Clerk: _____</p> <p>Date of HDIS Entry: _____</p>
--

<p><b>For Staff Use Only:</b></p> <p>Initials of Triage RN: _____</p> <p>_____</p> <p>Check Age: LAIV 19-49</p>
---

**2009 H1N1 INFLUENZA VACCINE CONSENT FORM FOR ADULTS**

You may be eligible to receive FluMist (nasal flu vaccine). Certain people must not receive FluMist. **You must answer each question below, and have the answers reviewed by the public health nurse to ensure that you are eligible to receive FluMist.**

<b>Precautions and Contraindications: Please mark YES or NO for each question.</b>		<b>YES</b>	<b>NO</b>
1.	Are you feeling well today?		
2.	Have you had any bad reaction to a previous flu shot?		
3.	Are you allergic to eggs, Gentamicin, Gelatin, Arginine, Sucrose, or Monosodium Glutamate (MSG)?		
4.	Are you allergic to a mercury preservative called thimerosal?		
5.	Has a doctor ever told you that you have an immune system disorder? *		
6.	Do you have AIDS, HIV, cancer, or have you received an organ transplant? *		
7.	Do you have any disease of the lungs, including chronic bronchitis, asthma, recurrent wheezing, emphysema, or cystic fibrosis? *		
8.	Did you ever have Guillain-Barre syndrome?		
9.	Do you have kidney disease? *		
10.	Are you pregnant or nursing? *		
11.	Do you have heart disease (angina, congestive heart failure) or have you ever had a heart attack or stroke? *		
12.	Do you have a blood disease like sickle cell disease or thalassemia? *		
13.	Do you currently have a respiratory illness or a fever? *		
14.	Have you received any vaccines within the last month or do you plan to receive any within the next month?		
15.	Are you taking any prescription medicines?		
16.	Do you have diabetes or other metabolic disease? *		
17.	Does anyone living with you have a compromised immune system? *		
18.	Are you in close contact with severely immunocompromised individuals who require a protective environment (such as bone marrow transplant recipients?)*		
19.	Have you received seasonal influenza FluMist within the past 28 days? *		

**Consent for Vaccine Administration:**

**I have read the information about 2009 H1N1 influenza vaccine and have truthfully answered all of the questions on this form. I have had the chance to ask questions and fully understand the benefits and risks of vaccination with 2009 H1N1 influenza vaccine. My signature below indicates my permission for 2009 H1N1 influenza vaccine to be given to me.**

\_\_\_\_\_  
Printed Name of Person to Receive Vaccine or  
Printed Name of Patient's Designee

\_\_\_\_\_  
Signature of Person to receive vaccine or  
person authorized to make request.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of RN completing assessment.

\_\_\_\_\_  
Date

Patient has been approved to receive FluMist:  
\_\_\_\_\_, RN

**CLINIC USE ONLY**

Vaccine Information Statements given as noted.

<b>Immunization Given</b>	<b>Lot #</b>	<b>Administration Site &amp; Route</b>	<b>Vaccine Adm. Signature/Title</b>
<b>2009 H1N1 Influenza</b>		<b>Left Deltoid IM</b>	
<b>2009 H1N1 FluMist</b>		<b>Intranasal</b>	