

**STICKNEY PUBLIC HEALTH DISTRICT
2009 H1N1 INFLUENZA VACCINE CONSENT FORM**

LAST NAME	FIRST NAME	(M.I.)	DATE OF BIRTH	AGE
HOME PHONE NUMBER ()	GENDER (check one) <input type="checkbox"/> Male <input type="checkbox"/> Female	RACE (check one) <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> Unknown or Other		
STREET ADDRESS		CITY	STATE	ZIP

IF CLIENT IS UNDER THE AGE OF 18 COMPLETE THE FOLLOWING SECTION

PARENT/LEGAL GUARDIAN'S LAST NAME	FIRST NAME	(M.I.)	RELATIONSHIP TO MINOR
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All questions and answers are about the person to receive the vaccine. The following questions will help us determine if and which type of vaccine is best for you or the person you consent for. Check the box that best describes your answer. If you have questions, ask the medical review staff.

	YES	NO	Unknown
1. Do you currently have a respiratory illness with a fever or an active infection today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Is your child 6-36 months old?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you pregnant or nursing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have an allergy to thimerosal (a mercury derivative)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you had a flu shot this year? Seasonal Flu Date: _____ H1N1 Vaccine Date: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Are you allergic to eggs or medicine? If yes, please list:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Has a doctor ever told you that you have an immune system disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have AIDS, HIV, cancer or have you received an organ transplant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have Rheumatoid Arthritis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have a history of asthma or reactive airway disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you have any disease of the lungs, including chronic bronchitis, emphysema or cystic fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Did you ever have Guillain-Barre syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you have kidney disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Do you have heart disease (angina, congestive heart failure) or have you ever had a heart attack or stroke?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Do you have a blood disease like sickle cell disease or thalassemia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you received any vaccines within the last month or do you plan to receive any within the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Are you taking any prescription medicines? List:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Are you currently receiving aspirin or aspirin-containing therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Do you have diabetes or other metabolic disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Are you in close contact or living with a severely immunocompromised individual(s) requiring a protective environment (such as bone marrow transplant recipients)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Do you have an active neurological condition (such as a seizure disorder)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I have truthfully answered all of the questions on this form. I have had someone explain to me and have received the Vaccine Information Statement for the H1N1 influenza vaccine. I have had the opportunity to ask questions regarding the vaccine and fully understand the benefits and risks of H1N1 Influenza vaccine. I understand that this is a voluntary vaccination. My signature below indicates my permission for the H1N1Influenza Vaccine to be given to me or the person named above for whom I am authorized to consent.

Signature: _____ Date: _____

DO NOT WRITE BELOW THIS LINE - FOR OFFICE USE ONLY

Medical Forms Review Signature: _____ Recommendation: FluMist 6-36 months Injectable Injectable (3yrs & up)

Signature and Title of Vaccinator: _____ Clinic Location: South North Central Other: _____

Vaccine	Date Dose Administered	Dose	Injection Site	Route	Dose Number	Vaccine Manufacturer	Lot Number	Exp. Date
<input type="checkbox"/> FluMist- LAIV <input type="checkbox"/> Injectable-Single Syringe <input type="checkbox"/> Injectable-Multi-Dose Vial			<input type="checkbox"/> LVL <input type="checkbox"/> RVL <input type="checkbox"/> LD <input type="checkbox"/> RD <input type="checkbox"/> N/A	<input type="checkbox"/> IM <input type="checkbox"/> Intranasal	<input type="checkbox"/> 1 st <input type="checkbox"/> 2 nd			