

HARRISON-CLARKSBURG HEALTH DEPARTMENT
2009 H1N1 INFLUENZA VACCINE CONSENT FORM

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

NAME (Last)	(First)	Middle Int.	PATIENT DATE OF BIRTH Month _____ Day _____ Year _____	
PARENT/LEGAL GUARDIAN'S NAME (Last)	(First)	Middle Int.	PATIENT AGE	PATIENT GENDER Male Female
ADDRESS			DAYTIME PHONE	
CITY	STATE	ZIP CODE	CELL PHONE	
SCHOOL NAME (IF APPLICABLE)			GRADE LEVEL (IF APPLICABLE)	

Section 2: Screening for Vaccine Eligibility

The following questions will help us know if you can get the 2009 HN influenza vaccine. Please mark YES or NO for each question. If you answer "NO" to all ten questions of the following questions, you can probably get the nasal spray influenza vaccine. If you answer "YES" to one or more of the following questions, you may be able to get the 2009 H1N1 injectable (via shot) vaccine, but we will discuss your options with you at the clinic.

QUESTIONS	YES	NO
1. Do you have any chronic illness or a weakened immune system?		
2. Do you have a serious allergy to eggs?		
3. Do you have any other serious allergies that you know of? Please list:		
4. Have you ever had a serious reaction to a previous dose of the flu vaccine?		
5. Have you ever had Guillain-Barre Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?		
6. Do you have a latex allergy?		
7. Have you ever previously received an H1N1 vaccine?		
8. If female, are you pregnant?		
9. Have you had Flu Mist (Nasal Spray), MMR, or Varicella (Chickenpox) vaccine in the past 4 weeks?		
10. Are you on Aspirin Therapy?		

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 to the STATE/LOCAL health department and it's staff to administer the H1N1 vaccine.

Patient/Parent/Legal Guardian

Signature _____

Date: month _____ day _____ year _____

Section 4: Permission to Release Information

In general, any information that is about your health, the health care you receive, or payment for that care is considered confidential and protected by the health information to carry out treatment, payment, healthcare operations, and/or other purposes. Our Notice of Privacy Practices provides a more complete description of permitted uses and disclosures. Please sign to acknowledge that a copy of our Notice of Privacy Practices has been made available to you.

Signature of Patient/Legal Guardian _____ Date _____

FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Dose administered	Route IM	Dose Number (1 st or 2 nd)	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator
2009 H1N1		R L Deltoid				
		R L THIGH				
2009 H1N1		R L Deltoid				
		R L THIGH				