



2009 H1N1 (SWINE FLU) Influenza Vaccine Consent Form Injectable

Harford County Health Department

Name (Last, First):

Address:

City: State: Zip:

Phone: - - Other Phone: - -

Date of Birth: / / Age: Gender: Male Female

Race (check all that apply): American Indian/ Alaska Native Asian Black/African American
 Native Hawaiian/Pacific Islander White Unknown
 Other (Specify) _____

Ethnicity: Hispanic or Latino? Yes No

MEDICAL SCREENING:

1. Do you have a serious allergy to eggs?..... Yes No
2. Have you ever had a serious reaction to any vaccine in the past?..... Yes No
3. Have you ever developed Guillain-Barre Syndrome within six weeks of getting an influenza vaccine?..... Yes No
4. Do you have a fever?..... Yes No

VACCINATION GROUP SCREENING:

5. Which dose of the H1N1 vaccine are you receiving today? Dose 1 Dose 2 Date Dose 1 given:
6. Are you pregnant? Yes No
7. Do you live with or care for children younger than 6 months of age? Yes No
8. Are you a health care or emergency medical service worker with direct patient care? Yes No
9. Are you between the ages of 6 months through 24 years of age?..... Yes No
10. Are you between the ages of 25 through 64 with an underlying risk factor such as asthma or other chronic health condition or a compromised immune system? Yes No

Consent and Request to Receive H1N1 Vaccination (please check box if agreed)

- I have read the information recorded above and certify that it is correct.
- I have received a copy of the Centers for Disease Control and Prevention (CDC) 2009 H1N1 Influenza Vaccine Information Statement (VIS) dated 10/2/09 and have read or had explained to me the information in the VIS.
- I have had an opportunity to ask questions about the 2009 H1N1 Influenza vaccine and they were answered to my satisfaction.
- I have received or been offered a copy of the Notice of Privacy Practices.
- I understand the risks and benefits of receiving the 2009 H1N1 Influenza vaccination and hereby give my consent to having the 2009 H1N1 Influenza vaccination administered to me or to the person named above for whom I am authorized to consent.

Signature _____

Relation to person receiving the vaccine _____

Date _____

For Clinic Use Only

Clinic Date: _____ Date VIS given: _____

Administration site: L Arm R Arm

Pediatric dose: _____ L Thigh R Thigh

Affix Label (Manufacturer, Lot #, Expiration Date, Vaccinator Initials) Here