

VINELAND HEALTH DEPARTMENT
 PO BOX 1508; 610 Montrose St, Suite 1
 VINELAND, NJ 08362-1508; Tel: 856-794-4000

2009 H1N1 Vaccine Consent Form

Section 1: Information about person receiving vaccine (PLEASE PRINT)

NAME (Last)	(First)	(M.I.)	DATE OF BIRTH ____/____/____ (month/ day / year)
MAILING ADDRESS			GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
CITY	STATE	ZIP	PHONE

Section 2: Screening for Vaccine Eligibility*

Please complete the questionnaire found on the **reverse side** of this consent form.

Section 3: 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 **Vineland Health Department** and associated staff to administer this vaccine to me or, if the name appearing above is a minor, to this individual as his/her parent/legal guardian. I also acknowledge and consent for my information to be added to the New Jersey Immunization Information System and that I have received a copy of the Notice of Privacy Practices.

Signature of Vaccinee/Parent/Legal Guardian _____ Date: _____
 Vaccinee/Parent/Legal Guardian (Print) _____
 Witness to Signature _____

Section 4: Observation period

It is recommended that you remain at the flu clinic site for 15 minutes after receiving your flu vaccine so clinic staff can monitor for any reactions you may experience.

FOR ADMINISTRATIVE USE ONLY

Vaccine	Date 1st Dose Administered	Date 2nd Dose Administered	Route/Site		Staff Signature	Vaccine Manufacturer	Lot Number
			1 st Dose	2 nd Dose			
Intranasal 2009 H1N1			<input type="checkbox"/> intranasal	<input type="checkbox"/> intranasal			
Injectable 2009 H1N1			IM <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Arm <input type="checkbox"/> Leg	IM <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Arm <input type="checkbox"/> Leg			

Patient name: _____

Date of birth: _____

Screening Questionnaire for Influenza Vaccination

For adult patients and parents/guardians of children to be vaccinated: The following questions will help us determine the most appropriate flu vaccine preparation to provide to you or your child or if there is any reason we should not give you or your H1N1 (swine) flu vaccine. If you do not understand a question, please ask a staff member to explain it.

	Yes	No	Don't Know
1. Is the person to be vaccinated sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the person to be vaccinated have an allergy to eggs or a component of the influenza vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the person to be vaccinated ever had a serious reaction to the influenza vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Is the person to be vaccinated younger than age 2 years or older than 49 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Does the person to be vaccinated have a long term health problem with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g. diabetes) or anemia or other blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. If the person to be vaccinated is a child age 2 years to 4 years, in the past twelve months, has a healthcare provider ever told you that they had wheezing or asthma ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Does the person to be vaccinated have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long term treatment With drugs such as high-dose steroids or cancer treatment with radiation or drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Is the child or teen to be vaccinated receiving aspirin containing therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Is the person to be vaccinated pregnant or could she become pregnant within the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Has the person to be vaccinated ever had Guillain Barre syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Does the person to be vaccinated live with or expect to have close contact with a Person whose immune system is severely compromised and who must be in a Protective isolation (such as in a hospital room with reverse air flow)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Has the person to be vaccinated received any other vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Form completed by: _____

Date: _____

For Administrative Use:

Form reviewed by: _____

Date: _____

Intranasal

Injectable

No vaccine