MADISON HEALTH DISTRICT
2009 H1N1 Influenza Vaccine Consent Form

Section 1: Complete for person to receive vaccine (please print)

NAME (Last)	(First)	(M.I.)	**DATE OF BIRTH** month________ day________ year __________	
PARENT/LEGAL GUARDIAN'S NAME (Last) **(if above less than 18 yrs.)**	(First)	(M.I.)	**AGE**	**GENDER** M / F
ADDRESS			**DAYTIME PHONE NUMBER:**	
CITY	**STATE**	**ZIP**		

Section 2: Screening for Vaccine Eligibility

If your child has already been vaccinated with 2009 H1N1 influenza vaccine, please tell us the number of doses and dates of vaccination.

☐ Dose 1 Date received: month ____day____year_______ Form (please circle): nasal spray shot

☐ Dose 2 Date received: month ____day____year_______ Form (please circle): nasal spray shot

The following questions will help us to know if you / your child can get the 2009 H1N1 influenza vaccine. Please mark YES or NO for each question.

A. Answer for the person to receive the H1N1 vaccine:

	YES	**NO**
1. Do you / your child have a serious allergy to eggs?	☐	☐
2. Do you / your child have any other serious allergies? (gentamycin, gelatin, arginine)	☐	☐
3. Has you / your child ever had a serious reaction to a previous dose of flu vaccine?	☐	☐
4. Has you / your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	☐	☐

B. There are two kinds of 2009 H1N1 influenza vaccine. Your answers to the following questions will help us know which of the two kinds of vaccine are best for you or your child.

	YES	**NO**
1. Has you / your child gotten vaccinated with any vaccine (not just flu) within the past 30 days? Vaccine: ______________________________ Date given: month______day_______year___________	☐	☐
2. Do you / your child have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood?	☐	☐
3. Are you / your child on long-term aspirin or aspirin-containing therapy (for example, does your child take aspirin every day)?	☐	☐
4. Do you / your child have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)?	☐	☐
5. Are you / your child pregnant?	☐	☐
6. Do you / your child have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?	☐	☐

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 its staff for the person named at the top of this form to be vaccinated with this vaccine.
(If this consent form is not signed and dated you / your child will not be vaccinated.)

Signature of Parent/Legal Guardian ____

Date: Month_________________ Day_____________ Year___________

Section 4:

By consenting to receive H1N1 vaccine I understand that this data will become part of the NJ Immunization Information Registry (NJIIS)

Section 5: Vaccination Record

FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Dose Administered	Route	DoseNumber (1st or 2nd)	Site	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator
2009 H1N1	/ /	☐ IM ☐ Intranasal		L thigh Rt. thigh L arm Rt. arm			
2009 H1N1	/ /	☐ IM ☐ Intranasal		L thigh Rt. thigh L arm Rt. arm			