Novel H1N1 Vaccine Consent Form

To be used only when consenting for self or for other (when consenting adult present)

PLEASE PRINT

Last Name: ______________________________________ First Name: _____________________________________ MI: ______

Date of Birth: ______________________ Age: ___________ Race: _______________________ Gender: Male_____ Female____

Address (Street) _________________________________City: ___________________ State: _________Zip Code: ____________

County: ____

Please answer the following questions:	YES	NO	DON'T KNOW
Is the person to be vaccinated sick today?	☐	☐	☐
Does the person to be vaccinated have an allergy to eggs or to a component of the influenza vaccine?	☐	☐	☐
Has the person to vaccinated ever had a serious reaction to intranasal Influenza vaccine (Flu Mist) or Influenza vaccine in the past?	☐	☐	☐
Has the person to be vaccinated ever had Guillain-Barre Syndrome?	☐	☐	☐
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 another blood disorder?	☐	☐	☐
If the person to be vaccinated is a child age 2 through 4 years, in the past 12 months has a healthcare provider ever told you that he or she had wheezing or asthma?	☐	☐	☐
Does the person to be vaccinated have a weakened immune system because of a disease that affects the immune system, long-term treatment with drugs such as high-dose steroids, or cancer treatment?	☐	☐	☐
Is the child or teen to be vaccinated receiving aspirin therapy or aspirin containing therapy?	☐	☐	☐
Is the person to be vaccinated pregnant or could she become pregnant within the next month?	☐	☐	☐
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)?	☐	☐	☐
Has the person to be vaccinated received an MMR, Chickenpox, Yellow Fever, Shingles, or FluMist Vaccine within the past 28 days?	☐	☐	☐

I have received, read, and understand the Novel H1N1 Vaccine Information Statement (VIS) and was provided the Notice of Privacy Practices (HIPAA). I have had a chance to ask questions and discuss my concerns with a healthcare professional.

I consent to use and disclosure of my medical information; for purpose of treatment, payment and healthcare operations. I consent to receive the Novel H1N1 vaccine.

Client or Representative Signature: ____Date________________________

Self or Representative's Relationship to Client: ___________________________________

For Office Use

Date of Vaccine________________ Vaccine Type_______________________________ Lot Number_________________________

Mfg. _________________________

Administered By: ____