



Will County Health Department H1N1 Influenza Vaccine Consent Form

LAST NAME	FIRST NAME	(M.I.)	DATE OF BIRTH & AGE Month ____ Day ____ Year ____ Age ____
ADDRESS		GENDER (circle one) MALE or FEMALE	RACE
CITY	STATE IL	ZIP	HOME PHONE NUMBER ()

IF PATIENT IS UNDER THE AGE OF 18 COMPLETE THE FOLLOWING SECTION

PARENT/LEGAL GUARDIAN'S LAST NAME	FIRST NAME	(M.I.)	RELATIONSHIP TO MINOR
-----------------------------------	------------	--------	-----------------------

The following questions will help us to know if you can get the H1N1 influenza vaccine and which type of vaccine you will receive. Please mark YES or NO for each question.	YES	NO
Do you currently have a cold or fever today?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a serious allergy to chicken eggs, egg protein, chicken, or chicken protein?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any other serious allergies? Please list: _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a serious reaction to a previous dose of flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been vaccinated with any vaccine (not just flu) within the past 30 days?		
Vaccine: _____ Date given: month ____ day ____ year ____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood?	<input type="checkbox"/>	<input type="checkbox"/>
Are you on long-term aspirin or aspirin-containing therapy (for example, do you take aspirin every day)?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a weak immune system? (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have close contact with a person who needs care in a protected environment? (for example, someone who has recently had a bone marrow transplant)	<input type="checkbox"/>	<input type="checkbox"/>

CONSENT FOR VACCINATION:

I have either had someone explain to me or have read the H1N1 Vaccine Information Statement for the H1N1 influenza vaccine. I have had the opportunity to ask questions regarding the vaccine. I understand the benefits and risks of the H1N1 Influenza Vaccine. I ask that the vaccine be given to me or the person named above for whom I am authorized to consent. I acknowledge receipt of the HIPAA Privacy Notice.

Signature: _____ **Date:** _____

This signature should be the signature of the person receiving vaccine or of the parent/legal guardian of child receiving the vaccine.

FOR ADMINISTRATIVE USE ONLY

Interviewer Signature: _____

Interviewer Recommendation:

- FluMist®
 Injectable Infant 6 – 35 mos.
 Injectable for age 3 yrs.
 Injectable for ages 4 – 18yrs.
 Injectable adult for ages 18 yrs +

Vaccine	Date Dose Administered	Route	Dose Number (1st or 2nd)	Vaccine Manufacturer	Lot Number	Injection Site	Clinic Location
2009 H1N1	/ /	<input type="checkbox"/> IM <input type="checkbox"/> Intranasal					

Signature and Title of Vaccine Administrator: _____ **Date:** _____