

Porter County Health Department

2009 H1N1 Influenza Consent

The Porter County Health Department cannot vaccinate unless **this form is completed entirely; signed and dated.**

Section 1: Information about Person Receiving Vaccine (please print)

Child or Adult's Name (Last)	(First)	(M.I.)	Date of Birth mo ____ day ____ year ____
Alias (Last)	(First)	Age	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>
Address:	City	State	Zip Code
Parent/Legal Guardian Name (Last)	(First)	M.I.	Daytime Phone #

Section 2: Screening for Vaccine Eligibility: Has person named above had a previous dose of H1N1 Vaccine?

A. Dose 1: Date Received: month ____ day ____ year ____ Form of vaccine (circle): Nasal Spray Shot

B. The person named above is (please circle):

1. Pregnant woman 2. Parent of child less than 6 months of age 3. Child 6 months to 24 years of age
4. Adult 25 - 64 years of age with chronic health issues 5. Healthcare/EMS worker 6. Other

C. The following information will help us determine if the person named above can get the 2009 H1N1 Influenza vaccine during this H1N1 Vaccination program. **Please mark YES or NO for every question.**

Please answer these questions to help us determine if person above can get the influenza vaccine at this clinic.	YES	NO
1. Does the person named on this form have a severe allergy to eggs?		
2. Does the person named on this form have any other serious allergies? List:		
3. Has the person named on this form ever had a serious reaction to a flu vaccine?		
4. Has the person named on this form ever had Guillain-Barré Syndrome (a temporary serious muscle weakness disease) within 6 weeks after receiving a previous dose of flu vaccine?		
5. Has the person named on this form received any live virus vaccine in the last 30 days? If "yes", list vaccine name(s) & date(s):		
6. Does the person named on this form have: asthma, diabetes, or other disease of the lungs, heart, kidneys, liver, nerves, or blood? (Please circle all that apply) list others:		
7. Does the person named on this form have a weak immune system (i.e. HIV, cancer/ meds, hi dose steroid)?		
8. Is the person named on this form pregnant?		
9. Does the person named on this form have a history of fainting?		

Answers to the above questions will determine whether you/your child is eligible for the H1N1 Nasal FluMist or the H1N1 Injectable Vaccine. If we cannot vaccinate today, the person named above may still be able to get the vaccine, check with your healthcare provider.

Section 3: Consent to Vaccinate: This form must be signed and dated to receive H1N1 Vaccine

I have received and read or had explained to me the 2009-2010 Vaccine Information Statement for the 2009 H1N1 Influenza Vaccine and I understand the risks and benefits of receiving the vaccine. I give permission to the Porter County Health Department and its staff to administer the H1N1 Influenza Vaccine to the person named above on this form. If the person named above is less than 10 years of age, I understand a 2nd dose of H1N1 vaccine is recommended at least 28 days from the first dose to give the greatest protection against the H1N1 virus.

Signed _____ **Relationship:** Self Parent/Guardian **Date** _____

Section 4: Vaccination Administration Record (Administrative Use Only)

Vaccine	Date Admin.	Route/Location IM deltoid R/L	MDV- Mist-SDS	Mfg	Lot Number	Vaccine Administrator
2009 H1N1						
2009 H1N1						

Entered by: _____ Date _____