

## 2009 H1N1 Influenza Immunization Screening and Consent Form\*

Recipient Name (please print)		Date of Birth		Date of Immunization			
Address		City		State Zip			
Parent/Guardian (if applicable, please print)		Sex		Phone		Medicare Claim Number	
		F   M					
Name of HMO/MCO, if Member		Health Care Provider's Name					
HMO/MCO Policy #, if Known		Health Care Provider's Address/Phone Number					
Clinic/Office Site Where Vaccine is Administered		Mother's Maiden Name: (optional - ?needed for children under age 19?)					

Indications	Is this your (your child's) first time getting the 2009 H1N1 (swine) flu vaccine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Are you (your child) between 6 months and 24 years of age?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you work in healthcare or emergency medical services?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	For ages 25 - 64 years, do you have a chronic or immunosuppressive medical condition?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Are you pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Are you a household contact or caregiver for children younger than 6 months of age?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Contraindications	Are you sick with fever today?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever had a serious reaction to the nasal spray or flu shot vaccine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have a severe allergy to eggs, a severe allergy to a component of the vaccine, or a severe allergic reaction (anaphylaxis) allergy to latex?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever had Guillain Barre' Syndrome?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
LAIV Contraindications	Do you have close contact with anyone with a severely weakened immune system or are you pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	For children ages 2 - 4 years, has your child had asthma or wheezing episodes in the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Is the child or teen to be vaccinated receiving long term aspirin treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

### Influenza Consent

I have read, or had explained to me, the information sheet about 2009 H1N1 influenza vaccination. I have had a chance to ask questions which were answered to my satisfaction and I understand the benefits and risks of the vaccination as described. I request that 2009 H1N1 influenza vaccination be given to me (or the person named above for whom I am authorized to make this request). I authorize the release of any medical or other information necessary to process a Medicare or other insurance claim or for other public health purpose.

Signature of Recipient (parent or guardian)

Date

### Area Below to be Completed by Vaccinator

Administration Site     Left Deltoid     Right Deltoid     Left Thigh     Right Thigh     Nasal

Dosage                     0.5 ml                     0.25ml                     LAIV

VIS Date \_\_\_\_\_                    Manufacturer & Lot Number \_\_\_\_\_

I have reviewed side effects with patient (parent or guardian)

Vaccinator Signature \_\_\_\_\_

Next Immunization Date:     Next Year                     In 4 weeks                     Other

\* Use of this form is optional.