

2009 H1N1 Influenza Vaccine Consent Form – Community Health KRHC

Information about the person to receive vaccine (please print clearly)

LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH	
PARENT/LEGAL GUARDIAN'S NAME			AGE	GENDER M / F
Mailing ADDRESS			PARENT/GUARDIAN DAYTIME PHONE NUMBER:	
CITY	STATE	ZIP		
CHILDCARE/PRESCHOOL/SCHOOL NAME				

Screening for Vaccine Eligibility

Children under the age of 10:

This age group will need to receive 2 doses of the 2009 H1N1 influenza vaccine. If your child has already been vaccinated with 2009 H1N1 influenza vaccine at a different clinic site, please tell us the number of doses and dates of vaccination.

- Dose 1 Date received: _____ Form (please circle): nasal spray shot
 Dose 2 Date received: _____ Form (please circle): nasal spray shot

The following questions will help us to know if you can get the 2009 H1N1 influenza vaccine. Please mark YES or NO for each question. If you answer "NO" to all four of the following questions, you/your child can probably get the influenza vaccine. If you answer "YES" to one or more of the following four questions, you/your child may be able to get the vaccine, but we will need to discuss your options.

	YES	NO
1. Do you/your child have a serious allergy to eggs?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you/your child have any other serious, life-threatening allergies? Please list: _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you/your child ever had a serious reaction to a previous dose of flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you/your child 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"/>

There are two forms of 2009 H1N1 influenza vaccine, nasal mist or shot. Your answers to the following questions will help us know which of the two forms of vaccine you/your child can get. (Based on vaccine availability & timing of last vaccination)

	YES	NO
1. Have you/your child been vaccinated with any vaccine (not just flu) within the past 30 days? Vaccine: _____ Date given: _____	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you/your child on long-term aspirin or aspirin-containing therapy (for example, taking aspirin every day)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you/your child have a weak immune system (for example; HIV, cancer, or medications such as steroids or those used to treat cancer)?	<input type="checkbox"/>	<input type="checkbox"/>
5. 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)?	<input type="checkbox"/>	<input type="checkbox"/>
6. Are you/your child pregnant? <input type="checkbox"/> NA	<input type="checkbox"/>	<input type="checkbox"/>

Consent

I have read or have had explained to me the 2009-2010 Vaccine Information Statement for the 2009 H1N1 influenza vaccine and understand the risks and benefits. I believe I understand these risks and benefits and GIVE CONSENT to Kossuth Community Health/KRHC and its staff to vaccinate my child or myself. I understand that if my child is under the age of 10 he/she will need to receive a second dose of this vaccine. This form gives consent for your child to receive two doses if he/she is under the age of 10 at a school-based clinic. **(If this consent form is not signed, dated, and returned, then your child will not be vaccinated at school).** I also understand the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I have certain rights to privacy regarding my protected health information. The Notice of Privacy Practice has been made available to me, which explains those rights.

Signature: _____ Date: _____
 (Parent/Legal Guardian signature for under age 18)

Check the vaccine priority group this individual fits into:

- Pregnant woman
- Person that lives with or cares for an infant younger than 6 months of age
- Healthcare or emergency medical personnel
- 6 months – 24 years of age
- 25 – 64 years of age with chronic health disorders or compromised immune systems

FOR CLINIC USE ONLY:

Vaccine	Date Dose Administered	Route/Site	Lot Number	Name and Title of Vaccine Administrator
Dose 1 - 2009 H1N1		IM <input type="checkbox"/> RD <input type="checkbox"/> LD <input type="checkbox"/> RT <input type="checkbox"/> LT Mist <input type="checkbox"/> Intranasal		
Dose 2- 2009 H1N1 (<10 yrs. of age)		IM <input type="checkbox"/> RD <input type="checkbox"/> LD <input type="checkbox"/> RT <input type="checkbox"/> LT Mist <input type="checkbox"/> Intranasal		