

## 2009 H1N1 Flu Vaccine Consent Form – Injectable Flu Shot Only

### Section 1: Information about Adult to Receive Vaccine (please print)

NAME (Last)	(First)	(M.I.)	DATE OF BIRTH / /
ADDRESS			DAYTIME PHONE NUMBER:
CITY	STATE	ZIP	
			GENDER M / F

### Section 2: Screening for Vaccine Eligibility

The following questions will help us know if you can get the 2009 H1N1 flu vaccine. Please mark YES or NO for each question.

If you are not sure of the answers to these questions, please check with you healthcare provider.

	YES	NO
1. Are you pregnant?		
2. Are the parent or sibling of infants younger than 6 mo. of age?		
3. Are you a health care worker with direct patient contact?		
4. Are you a household contact of pregnant women in their third trimester/		
5. Do you have a chronic illness?		
6. Do you have a serious allergy to eggs?		
7. Do you have a serious allergy to gentamicin, neomycin, polymixin or gelatin?		
8. Have you ever had a serious reaction to a previous dose of flu vaccine?		
9. Have you ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?		

List other serious allergies: \_\_\_\_\_

### Section 3: Consent

#### **CONSENT FOR ADULT VACCINATION:**

I have read or had explained to me the 2009-2010 Vaccine Information Statement for the H1N1 flu vaccine and understand the risks and benefits.

I GIVE CONSENT to get vaccinated with this vaccine. (If this consent is not signed, dated and returned, then you will not be vaccinated.)

Signature

Date: month \_\_\_\_\_ day \_\_\_\_\_ year \_\_\_\_\_

#### **FOR CLINIC USE ONLY:**

Lot # \_\_\_\_\_ Left Arm \_\_\_\_\_ Right Arm \_\_\_\_\_

Expiration Date \_\_\_\_\_ Nurse's Signature \_\_\_\_\_

Proof of Residency Shown \_\_\_\_\_