2009 H1N1 FLU VACCINE CONSENT FORM

Information collected on this form will be used to document permission for receipt of the 2009 H1N1 Influenza vaccine. Record of this immunization may be shared through the Wisconsin Immunization Registry (WIR) with other health care providers directly involved with the vaccinated person's care.

Information on person to receive vaccine

Name (Last, First, Middle Initial)			Gender ☐ Male ☐ Female
Birthdate Month _____ Day _____ Year ________	Age	Organization	Telephone Number ( )
Home Address P.O. Box City County State Zip Code			
Okay to share H1N1 immunization data with the Wisconsin Immunization Registry (WIR)? ☐ Yes ☐ No			

1. Are you sick today?	Yes	No
2. Does the person to receive vaccine have a serious allergy to eggs?	Yes	No
3. Does the person to receive vaccine have any other serious allergies? Please list:	Yes	No
4. Has the person to receive vaccine ever had a serious reaction or allergic response to past flu vaccinations?	Yes	No
5. Has the person to receive vaccine ever had Guillian Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	Yes	No

Your answers to the following questions will help us know which of the two kinds of vaccine you can receive.

5. Has the person to receive vaccine been vaccinated with any vaccine (including H1N1) within the past 4 weeks? (for example: nasal spray influenza, MMR, Varicella, etc.) Vaccines:____ Date Received: ____________________	Yes	No
6. Does the person to receive the vaccine have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood?	Yes	No
7. Is the person to receive the vaccine on long-term aspirin or aspirin-containing therapy (for example, does the person take aspirin every day)?	Yes	No
8. Does the person to receive the vaccine have a weakened immune system (for example, from HIV, cancer, or medications such as steroids)?	Yes	No
9. Is the person to receive the vaccine pregnant?	Yes	No
10. Does the person to receive the vaccine have close contact with a person whose immune system is severely compromised and who must be in protective isolation (such as in a hospital room with reverse air flow)?	Yes	No
11. Are you over 49 years of age?	Yes	No
12. In the last year, has the person to receive the vaccine received any blood products or immune globulin?	Yes	No

CONSENT FOR VACCINATION:

I have read or have had explained to me the 2009 Vaccine Information Statement for 2009 H1N1 Influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine be given to the person named above for whom I am authorized to make this request.

Signature: ____ Date: ______________________

FOR OFFICE USE

2009 H1N1: Route (circle one): IM or Nasal Body site (circle one): RD or LD Dose (circle one): 1 or 2

Manufacturer: ____ Lot No.: ___________________________

Signature and title of person administering vaccine: ____

Date vaccine administered: _______________________________