

2009 H1N1 Injectable Influenza Vaccine Consent Form

SECTION 1: INFORMATION ABOUT PERSON RECEIVING VACCINE (PLEASE PRINT)

| | | | |
|----------------------|---------|---|--|
| NAME (Last) | (First) | (M.I.) | DATE OF BIRTH ____ / ____ / ____ <i>month / day / year</i> |
| MAILING ADDRESS | | GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE | |
| CITY | STATE | ZIP | COUNTY |
| PARENT/GUARDIAN NAME | | RELATIONSHIP | PHONE NUMBER |
| PHYSICIAN NAME | | PHYSICIAN'S PHONE NUMBER | |

SECTION 2: SCREENING FOR INJECTABLE VACCINE ELIGIBILITY*

The following questions will help us to know if the person named above 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, the person named above can probably get the influenza vaccine. If you answer "YES" to one or more of the following four questions, you need to consult with your physician for guidance.

| | YES | NO |
|---|--------------------------|--------------------------|
| 1. Does the person named above have a serious allergy to eggs or to a component of the vaccine? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Is the person to be vaccinated sick today? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Has the person named above ever had a serious reaction to a previous dose of flu vaccine? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Has the person named above 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"/> |

SECTION 3: CONSENT FOR VACCINATION

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

I GIVE CONSENT to the STATE/LOCAL health department/healthcare provider and associated staff to administer this vaccine to me or, if the name appearing above is a minor, to this individual as his/her parent/legal guardian. I understand that the information contained within this record is being maintained to monitor immunization needs in order to prevent disease. This information is confidential and will only be shared with organizations or persons who are authorized by law to receive it. This includes the New Jersey Department of Health and Senior Services, a health care provider or health care organization providing treatment or health care services on behalf of an individual or on behalf of a child, a child's school or childcare and anyone else authorized under law to receive it. *(If this consent form is not signed, dated, and returned, then the person named above will not be vaccinated.)*

Signature of Vaccinee/Parent/Legal Guardian: _____

Vaccinee/Parent/Legal Guardian (Print): _____

Date: _____

Witness to Signature: _____

FOR ADMINISTRATIVE USE ONLY

| Vaccine | Date Dose Administered | Route/Site | Staff Initial | Dose Number (1st or 2nd) | Vaccine Manufacturer | Lot Number |
|-----------|------------------------|--|---------------|--------------------------|----------------------|------------|
| 2009 H1N1 | | IM <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Arm <input type="checkbox"/> Leg | | | | |
| 2009 H1N1 | | IM <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Arm <input type="checkbox"/> Leg | | | | |