



Greene County Combined Health District 2009 H1N1 Influenza Vaccine Consent Form



Section 1: Information to Receive Vaccine (please print)

NAME: (Last)		(First)	(M.I.)	DATE OF BIRTH: month _____ day _____ year _____	
PARENT/LEGAL GUARDIAN'S NAME: (Last)		(First)	(M.I.)	AGE:	GENDER: Male Female
ADDRESS:				PHONE NUMBER:	
CITY:	STATE:	ZIP:			

Section 2: Screening for Vaccine Eligibility

The following questions will help us to know if you can get the 2009 H1N1 influenza vaccine.

A. Please check all that apply.

- | | |
|---|---|
| <input type="checkbox"/> Is between 6 months and 24 years old | <input type="checkbox"/> Lives with or cares for children less than 6 months of age |
| <input type="checkbox"/> Is pregnant | <input type="checkbox"/> Works in healthcare or emergency services |
| <input type="checkbox"/> Is 25 thru 64 years old and has a chronic health condition
(Please list: _____) | <input type="checkbox"/> Does not fit any category but would like to be vaccinated |

B. If you answer "NO" to all four of the following questions, you can probably get the influenza vaccine. If you answer "YES" to one or more of the following four questions, you may be able to get the 2009 H1N1 vaccine; we will discuss your options.

1. Does the person have a serious allergy to eggs?	YES NO
2. Does the person have any other serious allergies? Please list: _____	YES NO
3. Has the person ever had a serious reaction to a previous dose of flu vaccine?	YES NO
4. Has the person ever had Guillain-Bare Syndrome (a temporary severe muscle weakness) within 6 weeks after receiving flu vaccine?	YES NO

C. There are two kinds of 2009 H1N1 influenza vaccine, nasal spray or injectable. Your answers to the following questions will help us know which of the two kinds of vaccine you can get.

1. Has the person received any of the following vaccinations within the past 30 days? MMR, Varicella, FluMist If Yes, give type and date. Recent vaccinations: _____ Date given: Month _____ Day _____ Year _____	YES NO
2. Does the person 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
3. Is the person on long-term aspirin or aspirin-containing therapy (for example, does the person take aspirin every day?)	YES NO
4. Does the person have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)?	YES NO
5. Is the person receiving the vaccine pregnant?	YES NO
6. Does the person have close contact with someone who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?	YES NO

Section 3: Consent

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 Greene County Combined Health District and its staff for the person named at the top of this form to receive this vaccine.

Signature of person/parent/legal guardian

Month/Day/Year

CONSENT FOR RELEASE OF INFORMATION:

I grant permission for the flu administration record to be released to the school, physician, and/or Ohio Department of Health as needed and within the guidelines of the Greene County Combined Health District's privacy policy.

Signature of person/parent/legal guardian

Month/Day/Year

Vaccine	Date Dose Administered	Route	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator
2009 HINI Dose 1	/ /	LD LT RD RT Intranasal	Sanofi Novartis CSL MedImmune		
2009 HINI Dose 2 (if <10 yrs)	/ /	LD LT RD RT Intranasal	Sanofi Novartis CSL MedImmune		

Office Use Only - Do not write below this line

GCCHD - FG - X - FB - J - C - YS - BV - BB