2009 H1N1 Intranasal Influenza Vaccine Consent Form

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

NAME (Last)	(First)	(M.I.)	**DATE OF BIRTH** _____ / _____ / _____ month / day / year
MAILING ADDRESS			**GENDER** ☐ **MALE** ☐ **FEMALE**
CITY	**STATE**		**ZIP**
COUNTY	**MUNICIPALITY**		

SECTION 2: SCREENING FOR INTRANASAL VACCINE ELIGIBILITY*

Please complete the questionnaire found on the reverse side of this consent form.

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 Intranasal Dose Administered**	**Staff Initial**	**Dose Number (1st or 2nd)**	**Vaccine Manufacturer**	**Lot Number**
2009 H1N1					
2009 H1N1					

Updated October 21, 2009

TEMPLATE

Patient name: _____ Date of birth: ____/____/____
(mo.) (day) (yr.)

Screening Questionnaire for Intranasal Influenza Vaccination

For adult patients as well as parents of children to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child intranasal influenza vaccine (FluMist) today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1. Is the person to be vaccinated sick today?	☐	☐	☐
2. Does the person to be vaccinated have an allergy to eggs or to a component of the influenza vaccine?	☐	☐	☐
3. Has the person to be vaccinated ever had a serious reaction to intranasal influenza vaccine (FluMist) in the past?	☐	☐	☐
4. Is the person to be vaccinated younger than age 2 years or older than age 49 years?	☐	☐	☐
5. Does the person to be vaccinated have a long-term health problem with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., diabetes), or anemia or another blood disorder?	☐	☐	☐
6. If the person to be vaccinated is a child age 2 through 4 years, in the past 12 months, has a healthcare provider ever told you that he or she had wheezing or asthma?	☐	☐	☐
7. Does the person to be vaccinated have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as high-dose steroids, or cancer treatment with radiation or drugs?	☐	☐	☐
8. Is the child or teen to be vaccinated receiving aspirin therapy or aspirin-containing therapy?	☐	☐	☐
9. Is the person to be vaccinated pregnant or could she become pregnant within the next month?	☐	☐	☐
10. Has the person to be vaccinated ever had Guillain-Barré syndrome?	☐	☐	☐
11. Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in a protective isolation (such as in a hospital room with reverse air flow)?	☐	☐	☐
12. Has the person to be vaccinated received any other vaccinations in the past 4 weeks?	☐	☐	☐

Form completed by: _____ Date: _____

Form reviewed by: _____ Date: _____

Technical content reviewed by the Centers for Disease Control and Prevention, September 2009.

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