County of Sacramento, Division of Public Health

Live (Intranasal) or Injectable H1N1 Influenza Vaccination Screening and Consent Form

H1N1 FLU VACCINE CONSENT FORM

Please read and answer ALL questions before signing the consent. Depending on your answers to the questions listed below you, or your child, will receive either the injectable H1N1 flu vaccine or the intranasal H1N1 flu vaccine. Please note that all children under 10 years of age need 2 doses at least 3-4 weeks apart.

NAME: _____ (First) _____ (Last) BIRTHDATE: _____ (mm-dd-yyyy) AGE: _____ SEX: Male or Female

PHONE: (___)_____ADDRESS:_____ CITY:_____ ZIP: _____

Please circle Yes or No for the following questions **and** answer **ALL** questions.

1) Is the patient allergic to eggs?	Yes	No
2) Has the patient ever had a Serious Allergic Reaction to the Influenza (Flu) Vaccine or to any other type of vaccine?	Yes	No
If yes, please explain:		
3) Has the patient received a FluMist flu vaccine, MMR and/or Varicella (chickenpox) vaccine in the past 4 weeks?	Yes	No
4) Does the patient have any chronic medical conditions such as heart disease or diabetes?	Yes	No
5) Was the patient ever told by a medical provider that he/she has asthma?	Yes	No
6) Does the patient take aspirin every day?	Yes	No
7) Has the patient ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	Yes	No
8) Is the patient pregnant?	Yes	No

I understand that, depending on the answers to the questions listed above, my child or I will receive either the injectable or the intranasal H1N1 flu vaccine. I have been given a copy of or have read the information contained in either the live, Intranasal H1N1 Influenza Vaccine or the Injectable H1N1 Influenza Vaccine information statement (VIS) dated 10/02/09. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and request that the vaccine indicated above be given to me or to the person named above for whom I am authorized to make the request.

Signature: _____ **Date:** _____

CLINIC USE ONLY

Date:	Dose:	Vaccine / Mfg:		Lot # Exp. Date:		Screening MD/RN/LVN	IZ Given By:	Site/Route
	#1							N / IM
	#2							N / IM