Anderson Hills Pediatrics - Consent Form for Free 2009 H1N1 Influenza Vaccine

Section 1: Information about the Person 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**
				M / F
ADDRESS				
CITY	**STATE**	**ZIP**		
DAYTIME PHONE NUMBER:				

Section 2: Screening for Vaccine Eligibility

If the person has already been vaccinated with 2009 H1N1 influenza vaccine, please tell us the number of doses and dates of vaccination.

Date received: month ____day____year_____ Form (please circle): nasal spray shot

Date received: month ____day____year_____ Form (please circle): nasal spray shot

The following questions will help us know if the person can get the 2009 H1N1 influenza vaccine. Please mark YES or NO for each question.

A. Please check all that apply for the person listed above:

_____ Is between 6 months and 24 years old

_____ Lives with or cares for children less than 6 months of age

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

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

C. There are two kinds of 2009 H1N1 vaccine. Your answers to these questions will help us know which of the two kinds of vaccine the person can get.

	YES	NO
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_____		
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?		
3. Is the person on long-term aspirin or aspirin-containing therapy (for example, does the person take aspirin every day)?		
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)?		
5. Is the person pregnant?		
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)?		

Section 3: Consent

CONSENT FOR VACCINATION:

I understand that I will receive the **2009-2010 Vaccine Information Statement** for the 2009 H1N1 influenza vaccine

I GIVE CONSENT to the Anderson Hills Pediatrics and its staff for the person named at the top of this form to receive this vaccine.
(If this consent form is not signed, dated, and returned, the vaccination will not be given)

Signature of Person/Parent/Legal Guardian _____ Date: month _____ day _____ year_____

Section 4: Vaccination Record (FOR ADMINISTRATIVE USE ONLY)

Vaccine	Date Dose Administered	Route		Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator
2009 H1N1		IM Intranasal				
Required Booster if < 9 years		IM Intranasal				