

Official Use Only: Priority Status

- | | | |
|--|--|---|
| <input type="checkbox"/> Pregnant women | <input type="checkbox"/> Person 6 months to 24 years old | <input type="checkbox"/> Healthcare workers and EMS personnel |
| <input type="checkbox"/> Household contacts of children under 6 months | <input type="checkbox"/> Adults, 25 years of age or older with serious chronic illness | |

2009 H1N1 Vaccine Consent Form

Name of Individual:

Last First Middle

Date of Birth: / /

Gender: Male Female

Language: English Spanish Other: _____

Address: _____

Street City, State, Zip Code

Home Phone: _____ **Emergency Phone:** _____

Birth State/Country: _____ **Primary Doctor:** _____

Consent Statement

I have been given the 2009-2010 CDC Vaccine Information Statement (VIS) for the 2009 H1N1 vaccine, read this document, and have no further questions at this time. I understand the risks and benefits of receiving the vaccine in either form and acknowledge that no guarantees have been made concerning the vaccine's success. I understand the side effects and warnings of the vaccine.

I give my permission to receive: (please check one box only)

- H1N1 Injection H1N1 Mist (nasal vaccine)

Signature of Participant: _____ **Date:** _____

Please answer the following questions: (Circle either Yes or No)

1 Do you have asthma, recurrent wheezing or active wheezing? Yes No

2 Have you received an H1N1 vaccination? Yes No

3 Have you ever had a life threatening reaction to ANY vaccination? Yes No

4 Do you have any allergies to items such as eggs, egg proteins, gentamicin, gelatin or arginine, or have a special medical condition? Yes No

If Yes, please explain: _____

5 Have you received any vaccinations within the past 30 days? Yes No

If Yes, please provide vaccination name and date: _____

6 Have you ever had Guillain-Barre syndrome? Yes No

7 Do you have any disease or take any medications that lower the body's immune system or have close contact with anyone who has a weakened immune system? Yes No

If Yes, please explain: _____

8 Do you have any of the following health problems? Yes No

Heart Disease Kidney Disease Diabetes Receiving aspirin or aspirin containing therapy

Other: _____

9 Are you pregnant or nursing? Yes No

Race: White Black Asian Other: _____

Hispanic: Non-Hispanic
 Cuban Mexican Puerto Rican
 Central American Dominican South American
 Other: _____

Health Plan: (this information is for statistical purposes only and will not be used to bill any organization)

Private Insurance No Insurance CHIP Medical Assistance-ACCESS-Medicaid
 Medicare Other:

Official Use: Provider Name: _____ Provider Initial: _____ Date: _____
Route: Intranasal Intramuscular- RD LD Lot # _____ Exp. Date: _____