

## 2009 H1N1 Influenza Immunization Screening and Consent Form

Name (please print)	Date of Birth	Age	Date of Immunization
Address	City	State	Zip
Parent/Guardian (please print)	Sex	Patient Phone	Medicare Claim Number
	F   M		
Name of HMO/MCO, If Member	Provider's Name		
HMO/MCO Policy #, If Known	Provider's Address		
Clinic/Office Site Where Vaccine is Administered	Mother's Maiden Name: (optional)		

Indications	Have you (your child) had any vaccine within the last 28 days, including the 2009 H1N1 flu vaccine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Are you (your child) between 6 months and 24 years of age?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you work in healthcare or emergency medical services?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	For ages 25 - 64 years, do you have a chronic or immunosuppressive medical condition?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Are you pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Are you a household contact or caregiver for children younger than 6 months of age?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Contraindications	Are you sick with fever today?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever had a serious reaction to the nasal spray or flu shot vaccine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have a severe allergy to eggs, a severe allergy to a component of the vaccine, or a anaphylactic allergy to latex?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever had Guillain Barre' Syndrome?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
LAIV Contraindications	Do you have close contact with anyone with a severely weakened immune system or are you pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	For children ages 2 - 4 years, has this child had asthma or wheezing episodes in the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Is this child or teen to be vaccinated receiving long term aspirin treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you recently or are you now taking antiviral medications?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

### Influenza Consent

I have read, or had explained to me, the Vaccine Information Sheet (VIS) about 2009 H1N1 influenza vaccination. I have had a chance to ask questions which were answered to my satisfaction and I understand the benefits and risks of the vaccination as described. I request that 2009 H1N1 influenza vaccination be given to me (or the person named above for whom I am authorized to make this request). I authorize the release of any medical or other information necessary to process a Medicare or other insurance claim or for other public health purpose.

\_\_\_\_\_  
Signature of Recipient (parent or guardian)

\_\_\_\_\_  
Date

### Area Below to be Completed by Vaccinator

Administration Site     Left Deltoid     Right Deltoid     Left Thigh     Right Thigh     Nasal  
 Dosage     0.5 ml     0.25ml     LAIV

VIS Date \_\_\_\_\_      Manufacturer & Lot Number \_\_\_\_\_

I have reviewed side effects with patient (parent or guardian)

Vaccinator Signature \_\_\_\_\_

Next Immunization Date:     Next Year     In 4 weeks     Other