



H1N1 INFLUENZA Vaccination Assessment, Release, and Consent Form

Please Print Clearly

Name: _____ Date: _____
(Individual Receiving Vaccine)

Gender: Male / Female Birth Date: ___/___/___

Address: _____ City: _____ State: _____ Zip: _____ County _____

School _____

PLEASE CHECK (✓) THE TARGET GROUP YOU QUALIFY FOR:

- 6 months – 24 years old
- Pregnant
- Healthcare worker or emergency medical services personnel
- 25-64 years old with an underlying medical condition
- Household contacts and caregivers for children younger than 6 months of age

Contraindications to Receiving the H1N1 Influenza Vaccination

- | YES | NO | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Have you ever had a severe (anaphylactic) reaction to an Influenza shot? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Are you allergic to eggs or egg products? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Are you allergic to thimerosal-containing products or mercury-containing products (i.e. eye contact lens solution)? |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Do you have a history of Guillain-Barre Syndrome? |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Do you currently have an acute febrile illness? |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Are you pregnant/think you might be pregnant? If yes, what trimester? |

Children under the age of 10: This age group will need to receive 2 doses of the 2009 H1N1 Influenza Vaccine. If your child has already been vaccinated with the 2009 H1N1 influenza vaccine at a different clinic site, please tell us the number of doses and dates of vaccination.

- | | | | | |
|---------------------------------|---------------------|----------------------|-------------|------|
| <input type="checkbox"/> Dose 1 | Date received _____ | Form (please circle) | nasal spray | shot |
| <input type="checkbox"/> Dose 2 | Date received _____ | Form (please circle) | nasal spray | shot |

I have read the H1N1 influenza vaccination information or have had the information explained to me. I have had a chance to ask questions and these have been answered to my satisfaction. I understand the benefits and risks of receiving the H1N1 influenza vaccine and ask that the vaccine be given to me. I accept responsibility for seeking medical attention for any problems with this vaccination.

Signature: _____ Date: _____