H1N1 Influenza Vaccine
Patient Screening and Consent

Section 1: Patient Information about the person receiving the H1N1 vaccine ---- PLEASE PRINT

Rx NAME: LAST	FIRST	SEX	BIRTHDATE	AGE
		M F	___/___/___ (mm) (dd) (yy)	

TELEPHONE NUMBER	STREET ADDRESS	CITY	COUNTY	STATE	ZIPCODE

Section 2: Health Screening Questions

Does the patient receiving the H1N1 vaccine have any of the following?	YES	NO
1. Currently have a fever or respiratory illness or other type of infection?	☐	☐
2. Sensitivity or allergies to foods (gelatin, eggs/egg protein) medication (gentamycin, Neosporin®, polymyxin B), vaccine components or have had a serious reaction to influenza vaccine in the past?	☐	☐
3. One of the following conditions or chronic illnesses?		
• Diabetes, heart problems, kidney problems, lung problems, including ashtma?	☐	☐
• History of recurrent or active wheezing, under the age of 5 years?	☐	☐
• Conditions that make it difficult to keep the airway clear (spinal cord injuries, paralysis, seizure disorders, cognitive disorders, neuromuscular disorders)?	☐	☐
• History of Guillian-Barre Syndrome; conditions that affect the immune system (HIV infection, cancer, chemotherapy, leukemia, chronic steroid treatment, asplenia, organ transplant)?	☐	☐
• Contact with others that have severely weakened immune systems being cared for in a protective environment (e.g. people with hematopoietic stem cell transplant)?	☐	☐
• Condition requiring long-term aspirin therapy and between the ages of 6 monghs -18 years of age?	☐	☐
5. Pregnant, breastfeeding or lactating?	☐	☐
6. Received any vaccine or antiviral medication (not just flu) within the past 30 days? ☐ Spray ☐ Shot Vaccine Name: Date given:	☐	☐

Section 3: Patient Consent for Vaccination (to be signed by patient, parent/legal guardian)

I have been given, read or had explained to me the 2009-2010 Vaccine Information Statement for the 2009 H1N1 influenza vaccine and understand the risks and benefits. I have had an opportunity to ask questions and GIVE CONSENT for myself or the child named at the top of this form to be vaccinated with this vaccine.

Signature of Patient, Parent/Legal Guardian________________________ Date: month______day______year__________

Section 4: For Office Use Only

Category of Person Receiving the H1N1 Vaccine (check appropriate box)

☐ Pregnant Women

☐ Healthcare and medical services personnel

☐ All persons 6 months of age through 24 year

☐ Household/caregivers of children less than 6 months of age

☐ Persons aged 25 through 64 years who have health conditions associated with higher risk of medical complications from influenza

☐ Healthy persons aged 25 through 64 years (only when more vaccine becomes available)

☐ Adults 65 years and older years (only when more vaccine becomes available)

Vaccine/Manufacturer	Route and Dose	Site	Lot Number	VIS Date
☐ H1N1 MedImmune	☐ 0.2 mL-1.0 mL/nostril	☐ NAS		10/01/2009
☐ H1N1 Novartis	☐ 0.25 mL PF	☐ RD		
☐ H1N1 Sanofi	☐ 0.5 mL PF	☐ LD		
☐ H1N1 CSL	☐ 0.5 mL	☐ RVL		
☐ H1N1 GSK		☐ LVL		

Clinic Name: *Address:*

Administered by: ______________________________ Date: ____________

Submit form to the Kitsap County Health District

INSTRUCTIONS ON THE BACK →