

**Wayne County Health Department  
2009 H1N1 Influenza Vaccine Consent Form - \*Adults 19 Years and Over\***

**Section 1: Information about Individual to Receive Vaccine (please print)**

NAME (Last)	(First)	(M.I.)	DATE OF BIRTH	AGE	Gender M / F
ADDRESS			DAYTIME PHONE NUMBER:		
CITY	STATE	ZIP	PHYSICIAN:		

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

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

	YES	NO
1. Are you sick today?	<input type="checkbox"/>	<input type="checkbox"/>
1. Do you have a serious allergy to eggs?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have any other serious allergies? Please list: _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had a serious reaction to a previous dose of flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>

**B. There are two kinds of 2009 H1N1 influenza vaccine. Your answers to the following questions will help us know which of the two kinds of vaccine you can get.**

	YES	NO
1. Have you gotten vaccinated with any vaccine (not just flu) within the past 30 days? Vaccine: _____ Date given: month _____ day _____ year _____	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you pregnant or trying to get pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?	<input type="checkbox"/>	<input type="checkbox"/>

**Section 2: Consent**

<p><b>CONSENT FOR VACCINATION:</b> I have read or had explained to me the 2009-2010 Vaccine Information Statement for the 2009 H1N1 influenza vaccine and understand the risks and benefits.</p> <p>I GIVE CONSENT to Wayne County Health Department and its staff to vaccinate me with this vaccine.</p> <p>Signature: _____ Medicare #: _____</p> <p>Date: month _____ day _____ year _____ Medicaid #: _____</p>
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**Section 3: Permission to Release Information**

<p>My signature above gives Wayne County Health Department permission to release information regarding my vaccinations to my health care provider.</p>
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**Section 4: Vaccination Record**

FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Dose Administered	Route	Site	Dose Number	Vaccine Manufacturer	Lot Number	VIS Received	Name and Title of Vaccine Administrator
2009 H1N1	/ /	<input type="checkbox"/> IM <input type="checkbox"/> Intranasal					<b>X</b>	

**Priority Group:** \_\_\_\_\_ Children age 2 years – 24 years      \_\_\_\_\_ Persons 25 – 64 Years with Health Condition  
 \_\_\_\_\_ Household contact of infant less than 6 months of age      \_\_\_\_\_ Healthcare & EMS Personnel      \_\_\_\_\_ Pregnant Woman