

H1N1 Influenza Vaccination Screening/consent

Name: _____
(Last) (first) (Middle initial)

Birth Date: _____ Age: _____ Sex: Male Female

Address _____ City: _____

State: _____ Zip: _____ Phone: _____

Please check which category applies to you

- pregnant women
- persons who live with or provide care for infants **aged <6** months (e.g., parents, siblings, and daycare providers),
- health-care and emergency medical services personnel (Direct patient contact)
- children aged 6 months–4 years
- children and adolescents aged 5–18 years.
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Please answer the following questions:	YES	NO	unsure
1. Are you sick today?			
2. Do you have any allergies, especially to eggs or latex?			
3. Have you had a flu shot before?			
4. Have you ever had a serious reaction to a vaccine in the past?			
5. Have you ever had Guillain-Barre' Syndrome?			
6. Are you pregnant, could you become pregnant in the next month?			
7. Is there a health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia or blood disorder?			
8. Are you taking blood thinners or on aspirin therapy?			

I grant permission to the Mercer County- Celina City Health Department to give the requested vaccination to myself or the person named above for whom I am authorized to make this request (as Parent or Guardian). I have read or had explained to me the information from the 2009-2010 Vaccine Information Statement and understand the risks and benefits of this vaccine. I have received or been offered the HIPAA Privacy Notice.

Please answer the following questions:	YES	NO	unsure
9. Have you had the intranasal influenza vaccine (FluMist®) in the past?			
10. Have you received any other vaccinations in the past 4 weeks?			
11. Are you taking an antiviral medication? (i.e., Tamiflu or Relenza)			
12. Do you or someone in your household have a weakened immune system or take chemotherapy?			
13. Do you have a muscle or nerve disorder?			
14. In the past 12 months, has a health-care provider ever told you that you had wheezing or asthma?			
15. Do you take steroids, anticancer drugs, or had radiation treatments in the past 3 months?			

Parent/guardian

signature: _____ **Date:** _____

For Health dept. use only

Clinic Site: _____

Vaccine Administered: H1N1 Influenza MIV H1N1 Influenza Mist LAIV

Manufacturer Influenza Vaccine & Lot number _____

Site of Administration: LDeltoid RDeltoid LThigh RThigh Nasal

Signature of Vaccine Administrator: _____

2nd dose required

Form reviewed by: _____ **Date:** _____