

**Broward County Health Department
2009 H1N1 Influenza Vaccine Consent Form (For Adults)**

For you to be eligible to receive the H1N1 Influenza vaccine, **you must answer all questions and sign this consent form.** Please read the vaccine information statements we have provided for you.

Section 1: Demographic Information (please print)

NAME (Last)		(First)	(M.I.)	DATE OF BIRTH Month _____ Day _____ Year _____		
ADDRESS				AGE	RACE	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female
CITY	STATE	ZIP	PHONE NUMBER(s)			

Section 2: Screening for Vaccine Eligibility

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

A. If you answer "NO" to all 4 of the following questions, you can probably get the H1N1 influenza vaccine. If you answer "YES" to 1 or more of the following questions, you will be screened to determine your eligibility.

Please check Yes or No for each question.	YES	NO
1. Do you have a fever, cough or any flu-like symptoms at this time?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have an allergy to eggs or any other allergies? Please list _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had a reaction to a previous dose of flu vaccine or to any other type of 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"/>

Please mark Yes or No for each question.	YES	NO
1. Have you been vaccinated with any vaccine (not just flu) within the past 30 days? Vaccine: _____	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have any of the following: asthma, diabetes, disease of the lungs, heart, kidneys, liver, nerves, or blood?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you take aspirin on a regular basis?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have a weakened immune system (e.g. HIV, cancer, or take medications such as steroids)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you pregnant or plan to become pregnant within the next 30 days?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have close contact with a person who has a severely weakened immune system (such as a bone marrow transplant, chemotherapy, etc...)?	<input type="checkbox"/>	<input type="checkbox"/>

Section 3: Consent

CONSENT FOR 2009 – 2010 H1N1 INFLUENZA VACCINATION:

I have received, read and understand the 2009-2010 Novel H1N1 Vaccine Information Statement. I have had the chance to ask questions and discuss my concerns with a healthcare professional.

I _____ (please print name), consent to be vaccinated with the 2009 -2010 Novel H1N1 influenza vaccine.

Signature _____ Date: Month _____ Day _____ Year _____

FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Dose Administered	Route	Site R DLT L DLT	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator
2009 H1N1	/ /	<input type="checkbox"/> IM <input type="checkbox"/> Intranasal				