

## 2009 H1N1 FLU VACCINE CONSENT

Community Clinics (Injectable)

Information collected on this form will be used to document permission for receipt of 2009 H1N1 influenza vaccine. Record of this immunization may be shared through the Wisconsin Immunization Registry (WIR) with other health care providers directly involved with the vaccinated person's care.

**Information on person to receive vaccine**

<b>Name (Last, First, Middle initial) please print</b>			<b>Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female		
<b>Birthdate</b> Month    Day    Year	<b>Parent/Guardian's Name (if applicable)</b>		<b>Telephone Number</b> (    )    )		
<b>Address</b>	<b>P. O. Box</b>	<b>City</b>	<b>County</b>	<b>State</b>	<b>Zip Code</b>
<b>Okay to share H1N1 immunization data with the Wisconsin Immunization Registry (WIR)?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No					

The four questions listed below are for screening purposes only and will help us determine if the person named above can receive the 2009 H1N1 vaccine and which type (injectable or Nasal). Please circle Yes or No.

- |  |            |           |
|--|------------|-----------|
| 1. Does the person to receive the vaccine have a serious allergy to eggs?  | <b>Yes</b> | <b>No</b> |
| 2. Does the person to receive the vaccine have any other serious allergies? Please List _____  | <b>Yes</b> | <b>No</b> |
| 3. Has the person to receive the vaccine ever had a serious reaction or allergic response to past flu vaccinations?  | <b>Yes</b> | <b>No</b> |
| 4. Has the person to receive the vaccine ever had Guillian Barré syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine? | <b>Yes</b> | <b>No</b> |

**CONSENT FOR VACCINATION:**

I have read, or have had explained to me, the 2009 Vaccine Information Statement for 2009 H1N1 influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine be given the person named above for whom I am authorized to make this request.

Signature X \_\_\_\_\_

Date \_\_\_\_\_

<b>FOR OFFICE USE</b>		VIS date: 10/02/009
2009 H1N1: Route (circle one) = IM or Intranasal (IN)	Body site (circle one) = RD, RV, LD, LV or IN	Dose (circle one): 1 or 2
Manufacturer _____ Lot No. _____		
Signature and title of person administering vaccine: _____		
Date vaccine administered: _____		