DOUGLAS COUNTY HEALTH DEPARTMENT –
H1N1 INFLUENZA INFORMATION/CONSENT FORM, *2009-2010*

CIRCLE

1. Do you/*your child* feel sick today or have a fever? Yes No

2. Have you/*your child* ever had *severe reaction* to the flu shot? Yes No
   ***if yes, please explain: _____

3. Have you/*your child* ever had gullain barre' syndrome? Yes No
   (this affects the central nervous system as an ascending/upwardly moving paralysis.)

4. Do you/*your child* have an allergy to chicken eggs?

5. Are you/*your child* allegic to neomycin, polymyxin or gentamicin? Yes No

6. Do you/*your child* have a weakened immune system (i.e. from hiv, cancer or medications such as steroids or those used to treat cancer)? Yes No

7. Do you/*your child* have asthma or other lung disease; heart disease? kidney disease; metabolic disease (i.e. diabetes), neurological, muscular (i.e. muscular dystrophy) or blood disorder? Yes No

8. Are you/*your child* on long-term aspirin (or aspirin containing) therapy? Yes No

9. Do you/*your child* have close contact w/ a person who needs to be in a protected environment (i.e. someone who recently had a bone marrow transplant) Yes No

10. Are you/*your child* (or could you be) pregnant? Yes No

11. Have you/*your child* had any vaccinations in the past 30 days? Yes No
    ***if yes, please list vaccinations _____

I *have read or have had explained to me the information on this form about H1N1 influenza and influenza vaccine. I have had a chance to ask questions which were answered to my satisfaction and was provided with a Vaccine Information Statement. I understand that the choice of vaccine will be based upon vaccine availability and recipient's health status. I understand the benefits and risks of influenza vaccine and request that the vaccine be given to me (or my child).*

X
Last Name (Please Print *Above*) **First** **Mi** **Dob** **Age**
X
Address (*Above*)
X
Signature of Recipient or *Parent/Legal Guardian if recipient is less than 19 years old* **Date**

6 - 35 months Yes No Pregnant Yes No Eligible for FluMist Yes No

THIS SECTION TO BE COMPLETED BY NURSING PERSONNEL ONLY

Vaccine Manufacturer	Lot #	Exp. Date	Inactive	Live	Dose #	Route	Site
☐ SANOFI PASTEUR ☐ NOVARTIS ☐ CSL ☐ GSK ☐ MEDIMMUNE		/ /	☐ 0. 5ml ☐ 0. 25ml	☐ 0.2ml	☐ 1 ☐ 2	☐ Intramuscular ☐ Intranasal	☐ Right Deltoid ☐ Right Thigh ☐ Left Deltoid ☐ Left Thigh

SCREENED BY:_____

ADMINISTERED BY: _____ **DATE:**_____

DOUGLAS COUNTY Health Department