OZAUKEEE COUNTY PUBLIC HEALTH DEPARTMENT
2009 H1N1 FLU VACCINE CONSENT FORM

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

Name (Last, First, Middle initial) please print			**Gender** Male Female
Birthdate: / / Mo Day Yr	**Age:**	**Parent/Guardian's Name (if applicable)**	**Telephone Number** ( )
Address	**P. O. Box**	**City**	**County** **State** **Zip Code**
Okay to share H1N1 immunization data with the Wisconsin Immunization Registry (WIR)? Yes No			

The 10 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?	YES	NO
2. Does the person to receive the vaccine have any other serious allergies? Please List _____	YES	NO
3. Has the person to receive the vaccine ever had a serious reaction or allergic response to past flu vaccinations?	YES	NO
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?	YES	NO

There are two types of 2009 H1N1 influenza vaccine (Injectable or Nasal Spray). Your answers to the following questions will help us know which of the two kinds of vaccine you can receive.

5. Has the person to receive the vaccine been vaccinated with any vaccine (including H1N1) within the past 4 weeks? (for example: nasal spray influenza, MMR, Varicella, etc) Vaccine(s): _____Date received: _____	YES	NO
6. Does the person to receive the vaccine have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood?	YES	NO
7. Is the person (child or teen) to receive the vaccine on long-term aspirin or aspirin-containing therapy (for example, does your child take aspirin every day)?	YES	NO
8. Does the person to receive the vaccine have a weakened immune system (for example, from HIV, cancer, or medications such as steroids)?	YES	NO
9. Is the person to receive the vaccine pregnant? Or, Breastfeeding?	YES	NO
10. Does the person to receive the vaccine have close contact with a person whose immune system is severely compromised and who must be in a protective isolation (such as in a hospital room with reverse air flow)?	YES	NO

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. □ H1N1 Injectable or □ H1N1 Nasal Spray or □ either is acceptable (based on eligibility and availability)

Signature **X**_____ Date _____

BELOW IS FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Dose Administered	Route	Dose Number	Vaccine Mfg	Lot Number	Name and Title of Interviewer
2009 H1N1	/ /	□ **IM** □ RD □ LD □ RV □ LV ******** □ **Intranasal**	**1** **2**			**Name and Title of Vaccine Administrator**