

Cook County Department of Public Health *Influenza A (H1N1) Vaccine Consent*

INFORMATION ABOUT THE PERSON TO RECEIVE VACCINE *(Please print)*

Place Client Identification Label Here

Name _____ Birthdate _____ Age _____ Sex F ___ M ___
 LAST FIRST Middle Initial Mo Day Year

Address _____
 STREET CITY COUNTY STATE ZIPCODE

Phone (_____) _____

Race: *(check one)*: ___BLACK ___WHITE ___ASIAN ___OTHER ___UNKNOWN

Ethnicity: *(check one)*: ___MEXICAN ___PUERTO RICAN ___CUBAN ___OTHER HISPANIC ___NON-HISPANIC ___ARABIC ___OTHER

| FOR EACH QUESTION place a check mark (✓) in the box that best describes your answer. | Yes | No |
|--|------------|-----------|
| 1. Has the person to be vaccinated had an Influenza A (H1N1) vaccination in the past 28 days? | | |
| 2. Does the person to be vaccinated have a sensitivity/allergy to latex? | | |
| 3. Does the person to be vaccinated have a history of Guillain-Barré syndrome? | | |
| 4. Does the person to be vaccinated have an illness with fever or other active infection? | | |
| 5. Does the person to be vaccinated have a serious allergy to eggs such as hives or difficulty breathing? | | |
| 6. Has the person to be vaccinated ever had a serious reaction to an influenza vaccination? | | |
| 7. Does the person to be vaccinated have a sensitivity/allergy to thimerosal? | | |
| 8. Does the person to be vaccinated live with or provide care to an infant less than 6 months of age? | | |
| 9. Is the person to be vaccinated between the ages of 6 months and 24 years of age? | | |
| 10. Does the person to be vaccinated have a chronic medical condition such as asthma, chronic obstructive pulmonary disease (COPD), diabetes, kidney, liver or heart disease, etc.? | | |
| 11. Is the person to be vaccinated pregnant? | | |
| 12. Is the person to be vaccinated younger than 24 months of age (2 years)? | | |
| 13. Is the person to be vaccinated 50 years of age or older? | | |
| 14. Has the person to be vaccinated received any of the following live virus vaccines: Influenza A (H1N1), FluMist, MMR (measles, mumps, rubella), or Varicella (chicken pox) in the past 28 days? | | |
| 15. Does the person to be vaccinated have a weakened immune system (for example: cancer, lymphoma, leukemia, HIV/AIDS, Lupus, etc.) that makes him/her more likely to contract an infection? | | |
| 16. Is the person to be vaccinated receiving any aspirin-containing therapy? | | |
| 17. Does the person to be vaccinated have an active muscular or neurologic disorder such as cerebral palsy that can lead to breathing or swallowing problems? | | |
| 18. Is the person to be vaccinated allergic to gentamicin, gelatin, or arginine? | | |
| 19. Will the person to be vaccinated have taken antiviral medications within 48 hours prior to vaccination? | | |
| 20. Is the person to be vaccinated in close contact with a person who has a severely weakened immune system requiring care in a protected environment such as a bone marrow transplant unit? | | |

I have read the Vaccine Information Statements (VIS) for both Live Attenuated Influenza A (H1N1) Vaccine and Inactivated Influenza A (H1N1) Vaccine or have had the information about these vaccines explained to me. I have had a chance to ask questions that were answered to my satisfaction and believe I understand the benefits and risks of Influenza A (H1N1) vaccine. I understand that the vaccinators will determine the type of Influenza A (H1N1) vaccine to be given based on my responses to the above questions. I consent and request that the vaccine be given to me or the person named on this form for whom I am authorized to make this request. I authorize the Cook County Department of Public Health (CCDPH) and the school or daycare center where the vaccine is administered to retain a record of this vaccination and further authorize these entities to release this form to the CCDPH, for use as permitted by applicable law. I acknowledge receipt of a CCDPH Notice of Privacy Practices.

PRINT name _____ Relationship to person _____
 vaccinated: *(check one)* ___Self
 ___Parent/Guardian
 ___Other

Signature of person to receive vaccine or person authorized to make the request on his/her behalf: _____

X _____ Date: _____

FOR CLINIC USE ONLY

Comments: _____

| Date Vaccinated | VIS Date | Manufacturer and Lot # | Site of Administration | Signature of Vaccine Administrator |
|-----------------|----------|------------------------|---|------------------------------------|
| | | | IN=Intranasal LD=Left deltoid RD=Right deltoid LT=Left thigh RT = Right thigh | |
| | | | | |