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 vaccinator 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:____________

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Comments:______________________________

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