

2009-2010 H1N1 Flu Vaccine Consent Form --Injectable Flu Shot or Nasal Spray Vaccines
(FOR ADULT IMMUNIZATION)

Winthrop Health Department, 1 Metcalf Square Rm. 5, Winthrop, MA 02152

Section 1: Information about you to Receive Vaccine (please print)

NAME (Last)		(First)		(M.I.)	DATE OF BIRTH	SOCIAL SECURITY #
ADDRESS		CITY	STATE	ZIP	AGE	GENDER <input type="checkbox"/> M <input type="checkbox"/> F
INSURANCE NAME:		INSURANCE #:				

Section 2: Screening for Vaccine Eligibility

If you have already been vaccinated with 2009 H1N1 flu vaccine, please tell us the date of vaccination.

Dose 1 Date received: month _____ day _____ year _____
 Form (please circle): nasal spray shot

The following questions will help us to know if you can get the 2009 H1N1 flu vaccine. Please mark YES or NO for each question.
 A. If you answer "YES" to one or more of the four questions, you will not be able to receive the 2009 H1N1 flu vaccine unless there is documentation from your health care provider approving the vaccination. If you answer "NO" to the following questions you will receive the vaccine unless a concern arises following additional screening. If you are not sure of the answers to these questions, please check with your health care provider.

1.	Do you have a serious allergy to eggs?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Do you have a serious allergy to gentamicin, neomycin, polymixin or gelatin?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Have you ever had a serious reaction to a previous dose of flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Have you ever had Guillain-Barre Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
YES	NO	YES	NO

B. There are two kinds of 2009 H1N1 flu vaccine. Your answers to the following questions will help us determine if you are able to receive the nasal spray vaccine.

1.	Have you been vaccinated with any vaccine (not just flu) within the past 30 days?	<input type="checkbox"/>	<input type="checkbox"/>
Vaccine:	Date given: month _____ day _____ year _____	<input type="checkbox"/>	<input type="checkbox"/>
2.	Do you have any of the following: asthma, diabetes, or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood? (Circle One if applicable)	<input type="checkbox"/>	<input type="checkbox"/>
3.	Are you on long-term aspirin or aspirin-containing therapy (for example, do you take aspirin every day)?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Do you have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Do you have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?	<input type="checkbox"/>	<input type="checkbox"/>
YES	NO	YES	NO

List other serious allergies: _____

Section 3: Consent

I have read or had explained to me the 2009-2010 Vaccine Information Statement for the H1N1 influenza vaccine and understand the risks and benefits.
 I GIVE CONSENT to get vaccinated with this vaccine. (If this consent is not signed, dated and returned, then I will not be vaccinated.)

Signature: _____ Date: _____

Signature: _____ Date: _____

I DO NOT GIVE CONSENT to get vaccinated with this vaccine.

PLEASE BE SURE TO READ AND SIGN THE REVERSE SIDE OF THIS FORM

Section 4: Permission to Share Information:

I, _____, give permission to the individual and/or entity that administered the 2009 H1N1 vaccine to me to share copies of the 2009 H1N1 consent form and vaccination record with my health care provider named below, as well as with the Massachusetts Department of Public Health and the local board of health in my community. I also give permission for each of these entities to share the 2009 H1N1 consent form and vaccination record with each other.

My Health Care Provider:

Name: _____
 Address: _____
 City: _____
 State: _____
 Zip: _____
 Phone Number: _____

• This health information is disclosed at my request and to ensure that I am appropriately vaccinated.

• If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information received may no longer be protected by federal privacy regulations. State

Health. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain the vaccination.

• I understand that I may inspect or copy the protected health information to be disclosed under this permission to share.

• Finally, I understand that I may withdraw this permission in writing at any time by sending written notification to:

RO SARRO, RN/BSN PUBLIC HEALTH NURSE Phone #: 617-846-1740 ext.130
WINTHROP HEALTH DEPARTMENT, 1 METCALF SQUARE, RM 5, WINTHROP, MA 02152

However, if I withdraw permission at a later date, any vaccine consent form and vaccine record already shared will not be covered by the withdrawal.

Print Name: _____
 Address: _____
 Date: _____
 State: _____
 Zip: _____
 Signature: _____

 For Clinic/Office Use: Contact Person: _____ RO SARRO, RN/BSN PUBLIC HEALTH NURSE Phone #: 617-846-1740 ext.130

Vaccine	Vaccine	Manufacturer:	Number:	Date Vaccine Administered:	Vaccine Type: (Circle)	Site: (Circle)	Route: (Circle)
H1N1					Dose #1	Right Arm	Intramuscular
					Dose #2	Right Leg	Intranasal

Clinic Site Name: WINTHROP HEALTH DEPARTMENT Site PIN#: 11812
 Clinic Address: 1 METCALF SQUARE, Rm. 5, WINTHROP, MA 02152 Vaccine Administrator: _____
 Date Vaccine Information Statement (VIS) given: _____ Date on VIS: _____
 Signature of Vaccine Administrator: _____ Date: _____

Permission to share is compliant with HIPPA for billing and information sharing purposes