

**Stanly County Health Department  
2009-2010 H1N1 Influenza Vaccine Consent Form**

Patient Name \_\_\_\_\_  
(Please Print) Last First MI Date of Birth Race Sex

Address City State Zip County

Home Phone (xxx) xxx-xxxx Yes No Hispanic Social Security Number xxx-xx-xxxx

Mother's Maiden Name \_\_\_\_\_ Mother's first name \_\_\_\_\_

	Yes	No	If yes to any of these screening questions, client not eligible for H1N1 FluMist
Have you received the MMR or varicella (chickenpox) vaccine in the past 30 days?			
Have you taken Tamiflu or Relenza within the past 2 weeks?			
Have you ever had a life-threatening reaction to any type of FLU vaccine in the past?			
Do you have a <b>severe</b> allergy to eggs, gentamicin, gelatin, or arginine, or thimerisal?			
Are you currently receiving long-term aspirin treatment?			
Do you have a history of Guillain-Barré Syndrome?			
Do you have a disease such as cancer, lupus, or HIV/AIDS or takes medication such as steroids or chemotherapy that lowers the body's resistance to infection?			
Do you have a health concern such as chronic heart disease, lung disease, kidney disease, liver disease, muscle or nerve disease (such as seizures), diabetes, blood disease (such as sickle cell anemia), or may be pregnant?			
Do you frequently visit someone who has a severely weakened immune system such as a person who has had a bone marrow transplant <b>AND CURRENTLY</b> is in a negative pressure room in the hospital <b>OR</b> is currently in the hospital on chemotherapy?			
Have you been diagnosed with asthma <b>OR</b> less than five (5) years of age and have had multiple episodes of wheezing, or had a wheezing episode in the last twelve (12) months.			
Have you received a FLU vaccine this fall (2009).			
Are you allergic to latex?			XX

**CONSENT FOR FLU SHOT-NOTICE OF PRIVACY PRACTICE**

I have read or have had explained to me the information on the Vaccine Information Sheet about the H1N1 Influenza vaccine. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the risks and benefits of influenza vaccine and request that the influenza vaccine be given to me or the person named above for whom I am authorized to make this request. I have been provided access to the Stanly County Health Department Notice of Privacy Practices.

X \_\_\_\_\_  
Signature of recipient or authorized person (\*Age 18 and under require parental consent) Date

INFORMATION FOR OFFICE AND CLINICAL USE ONLY	
<input type="checkbox"/> Clinic	<input type="checkbox"/> Employee
<input type="checkbox"/> Other _____	
VIS: English 10/2/09 Spanish _____	
Date ____/____/____ Sec. Initials _____	
<div style="border: 1px solid black; width: 100%; height: 100%; display: flex; align-items: center; justify-content: center;"> <span>Place label here</span> </div>	
Injection Site: IM Deltoid ____ Right ____ Left	Mid-Lateral Thigh ____ Right ____ Left
H1N1 FluMist (LAIV) _____	Nurse Signature: _____