

District Health Department #10
2009 H1N1 Influenza Vaccine Screening & Consent Form: General Clinic

NAME: _____ **Date of Birth:** _____/_____/_____
(Last) (First) (MI) (month) (day) (year)

Please check YES or NO for each question.

ALL Vaccine Recipients:

1. Are you feeling sick today? ----- YES NO
2. Will this be your first flu vaccine ever? ----- YES NO
3. Have you had any allergies or **serious** reactions to vaccines, medications, or foods, including eggs? ----- YES NO
If Yes, what? _____
4. Have you ever had Guillain-Barre Syndrome (GBS)? ----- YES NO

Nasal Spray Vaccine ONLY:

1. Are you between the ages of 2 years and 49 years? ----- YES NO
2. Have you received any vaccines, including flu vaccines, in the past 30 days? ----- YES NO
If Yes, what? _____
Date given: month _____ day _____ year _____
3. Do you have any of the following: recurrent wheezing, asthma, diabetes, metabolic disease, or disease of the lungs, heart, kidneys, liver, nerves, muscles, or blood? ----- YES NO
4. If under age 18, are you on long-term aspirin therapy (for example, take aspirin every day)? ----- YES NO
5. Do you have a weak immune system (for example, from HIV, cancer, or medications such as steroids or cancer treatments)? ----- YES NO
6. If female, are you pregnant? ----- YES NO
7. Do you have close contact with anyone who needs care in a protected environment (for example, had a recent bone marrow transplant)? ----- YES NO
8. Have you taken any antiviral medications in the past week (for example, Tamiflu or Relenza)? ----- YES NO

CONSENT for Vaccination:

I acknowledge I have received and have read, or had explained to me, the information contained in the appropriate 2009 H1N1 Influenza Vaccine Information Statement. I understand the risks and benefits and give consent for this vaccine to be given to me, or to the person named above for whom I am authorized to provide consent. I understand that vaccine administration will be recorded on the Michigan Care Improvement Registry (MCIR) Scan Form and in the Registry itself.

I have been offered information on the Notice of Privacy Practices from District Health Department #10, available from any Health Department office and at www.dhd10.org. I understand the Notice contains my rights and the Health Department's responsibilities regarding my protected health information.

SIGNATURE: _____ **DATE:** _____