

**Cleveland County Health Department
Consent for H1N1 Flu Vaccine**

PLEASE PRINT

If you have insurance or Medicare check all that apply & give card to clerk to copy)

Medicare Private Insurance

Last Name		First Name		Middle Initial	Birthdate	Age
Race	Sex	Social Security Number			Marital Status	
Address (Street number and name)					City	
State	Zip Code	County	Phone Number			

Cleveland County Health Department Notice of Privacy Practices Given

I have read or have had explained to me the information in the appropriate *Influenza Vaccine Information Statement*. I have had a chance to ask questions and they were answered to my satisfaction. I believe I understand the benefits and risks of receiving the Flu vaccine and ask that the vaccine be given to me or to the above named person for whom I am authorized to make this request. To the best of my knowledge, I am not allergic to any component of the Flu vaccine and do not have any other medical condition that would prevent me from receiving the vaccine.

× _____ **Date:** _____
Signature of person authorized to give consent

For Clinic / Office Use:

Date Administered ;	L thigh	R thigh	L deltoid	R deltoid
Administrator:	Inhaled			
_____	Prov. # _____			
VIS Date 10/02/2009				

Triage staff to circle vaccine

<u>Vaccine</u>	<u>Manufacturer</u>	<u>Lot#</u>	
FluMist	Medimmune	500801P	Age 2-49
Fluzone	Sanofi Pasteur	UP021AA	Age 6mo-up
Fluzone	Sanofi Pasteur	UT014FA	Age 6mo-35 mo

Insurance / Medicare / Medicaid Information

Payor: _____	Medicaid # _____
Insured Name _____	Effective Date: _____
Insured SS# _____	Insured DOB: _____
Policy #: _____ Group #: _____	Effective Date: _____

COMPLETE QUESTIONS ON BACK OF FORM

For Ages 2 through 49 Years

Please circle “Yes” or “No” for each of the following questions. All questions MUST be answered .These questions pertain to both you or child. You or your child may be eligible to receive FluMist (Live Attenuated Influenza Vaccine or LAIV), the inhaled form of the flu vaccine.

I/ my child have received the MMR / Varicella (chickenpox) or seasonal/H1N1 live virus vaccine in the past four (4) weeks.	Yes	No
I/ my child have had a life-threatening reaction to FLU vaccine in the past.	Yes	No
I/ my child have a severe allergy (hives or trouble breathing) to eggs, gentamicin, gelatin, MSG or arginine (all contained in the flu vaccine).	Yes	No
My child is currently receiving long-term aspirin treatment.	Yes	No
I/ my child have a history of Guillain-Barré Syndrome.	Yes	No
I/ my child 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.	Yes	No
I/ my child 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.	Yes	No
I/my child frequently visit someone who has a severely weakened immune system such as a person who has had a bone marrow transplant AND CURRENTLY is in a negative pressure room in the hospital OR is currently in the hospital on chemotherapy.	Yes	No
I/my child has received a FLU vaccine this fall (2009).	Yes	No
I/my child have been diagnosed with asthma OR has had multiple episodes of wheezing, or had a wheezing episode in the last twelve (12) months.	Yes	No