

**GREATER MONADNOCK PUBLIC HEALTH NETWORK-ALL HAZARDS HEALTH REGION 8
H1N1 INFLUENZA VACCINE CONSENT**

Complete in full – Please print clearly

Date		Location of Clinic		
First Name		Home Address		
Last Name		City	State	Zip
Birth Date	Age	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Phone

Please answer all questions		YES	NO
	You may inform my physician of this immunization: Dr. _____		
1	Are you allergic to eggs?		
2	Are you sick with a fever today?		
3	Have you ever had a bad reaction to a flu or other vaccine?		
4	Do you have a history of Guillain Barre Syndrome?		
5	Are you currently on anticoagulation therapy?		
6	Do you have a history of wheezing or Asthma ?		
7	Do you have a long term problem with weakened immune system, heart, lung, liver, kidney or metabolic disease (includes diabetes), or, do you have a neuromuscular disease which can cause difficult swallowing?		
8	Do you live with or care for a person who is severely immune suppressed.		
9	Are you pregnant or nursing?		

If the answer to any questions 6 -9 is yes – you will be given the inactivated vaccine by injection.

If answers 1-9 are NO and you are under 50 years of age, you will be given the nasal mist vaccine.

I have had the opportunity to read the CDC Vaccine Information Statement(s) for H1N1 Influenza Vaccine dated 10/2/09 or had the information explained to me. I have had a chance to ask questions, which were answered to my satisfaction. I believe I understand the benefits and risks of the influenza vaccine. I ask that the vaccine be given to me or to the person named above, for whom I am authorized to make this request. If any adverse effects from the flu vaccination occur after I leave, I agree to contact my physician.

Signature: _____
Person to receive vaccine or person authorized to make request

Date: _____

Inactivated vaccine: Route of Admin: IM Dose: 0.5 ml Site: <input type="checkbox"/> Lt Deltoid <input type="checkbox"/> Rt Deltoid	Manufacturer: Lot: Expiration Date:
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Nasal Mist LAIV Route of Admin Intranasal Dose: 0.1 ml each nostril	Manufacturer: Lot: Expiration Date:
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Signature: _____
Person giving vaccine

Date: _____