

**H1N1 INFLUENZA (Swine Flu) IMMUNIZATION  
Consent Form (v.11/13/09)**

(PLEASE PRINT CLEARLY AND FIRMLY, INCOMPLETE FORMS WILL BE RETURNED)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Gender: ( M / F )  
 Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Mother's Maiden Name: \_\_\_\_\_  
 Current Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 Race: (circle one) AI/AN-Am Indian/Alaska Native A-Asian W- White B-Black O-Other Ethnicity: H – Hispanic NH – Non-Hisp

**INSURANCE INFORMATION**

American Indian/Alaska Native  Private Insurance Co. \_\_\_\_\_  Medicaid/Salud \_\_\_\_\_  
 No Health Insurance  Underinsured (Have commercial/private health insurance but coverage does not include vaccines, covers only selected vaccines, or insurance caps vaccine coverage at a certain amount.)

1. Are you allergic to eggs? .....  Yes  No  Don't Know
2. Have you ever had Guillain-Barré syndrome (a type of temporary severe muscle weakness)? .....  Yes  No  Don't Know
3. Have you received a flu vaccination before? .....  Yes  No  Don't Know
4. Have you ever had a serious reaction to flu vaccine in the past? .....  Yes  No  Don't Know
5. Have you received any other vaccines in the past 4 weeks? .....  Yes  No  Don't Know  
 If yes, which one(s): \_\_\_\_\_ Date given: \_\_\_\_\_
6. Are you allergic to gentamicin sulfate, gelatin or MSG? .....  Yes  No  Don't Know
7. Do you have asthma or other lung disease? .....  Yes  No  Don't Know
8. Do you have long-term health problems with heart disease? .....  Yes  No  Don't Know
9. Do you have kidney disease or renal dysfunction? .....  Yes  No  Don't Know
10. Do you have blood diseases (such as sickle cell anemia)? .....  Yes  No  Don't Know
11. Do you have diabetes? .....  Yes  No  Don't Know
12. Are you on long-term aspirin therapy? .....  Yes  No  Don't Know
13. Do you have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long term treatment with drugs such as steroids, or cancer treatment with x-rays or drugs?  
 .....  Yes  No  Don't Know
14. Are you pregnant or planning to become pregnant in the next month? .....  Yes  No  Don't Know

Please list any allergies: \_\_\_\_\_

I have been given a copy and have read, or have had explained to me, the information in the "Vaccine Information Statements" for influenza and the influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the influenza vaccine requested and ask that the influenza vaccine be given to me. I agree to report any problems that arise, and direct any questions I may have, to my doctor/health care provider.

I agree to allow information on immunizations given to me to be released to other medical care providers to avoid unnecessary vaccination or to ascertain immunization status. I also understand that my medical care provider may release this information to the state immunization registry (NMSIIS) unless I sign a document indicating my refusal.

Signature of client \_\_\_\_\_ Date \_\_\_\_\_

**FOR CLINIC USE (This section must be completed by the medical provider)**

Vaccine	Date Vaccinated	Site of Injection/admin	Dose #	Vaccine Manufacturer	Lot Number	Provider Signature
2009 H1N1	/ /	<input type="checkbox"/> IM _____ <input type="checkbox"/> Intranasal	<input type="checkbox"/> 1st	<input type="checkbox"/> MedImmune (nasal spray) <input type="checkbox"/> SanofiPasteur <input type="checkbox"/> GSK * <input type="checkbox"/> Novartis <input type="checkbox"/> CSL	Lot # _____	_____
2009 H1N1	/ /	<input type="checkbox"/> IM _____ <input type="checkbox"/> Intranasal	<input type="checkbox"/> 2nd	<input type="checkbox"/> MedImmune (nasal spray) <input type="checkbox"/> SanofiPasteur <input type="checkbox"/> GSK * <input type="checkbox"/> Novartis <input type="checkbox"/> CSL	Lot # _____	_____

\* For ≥ 18 years and older only

Clinic ID# \_\_\_\_\_ NMSIIS entry completed