

# Cook County Department of Public Health *Influenza A (H1N1) Vaccine Consent*

## INFORMATION ABOUT THE PERSON TO RECEIVE VACCINE (Please print)

*Place Clinic Identification Label Here*

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Sex F \_\_\_ M \_\_\_  
LAST FIRST Middle Initial Mo / Day / Year

Address \_\_\_\_\_  
STREET CITY COUNTY STATE ZIPCODE

Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Race: (check one):  BLACK  WHITE  ASIAN  OTHER  UNKNOWN

Ethnicity: (check one):  MEXICAN  PUERTO RICAN  CUBAN  OTHER HISPANIC  NON-HISPANIC  ARABIC  OTHER

| FOR EACH QUESTION place a check mark (✓) in the box that best describes your answer.   | Yes | No |
|--|-----|----|
| 1. Has the person to be vaccinated had an Influenza A (H1N1) vaccination in the past 28 days?  |     |    |
| 2. Does the person to be vaccinated have a sensitivity/allergy to latex?   |     |    |
| 3. Does the person to be vaccinated have a history of Guillain-Barré syndrome?   |     |    |
| 4. Does the person to be vaccinated have an illness with fever or other active infection?  |     |    |
| 5. Does the person to be vaccinated have a serious allergy to eggs such as hives or difficulty breathing?  |     |    |
| 6. Has the person to be vaccinated ever had a serious reaction to an influenza vaccination?  |     |    |
| 7. Does the person to be vaccinated have a sensitivity/allergy to thimerosal?  |     |    |
| 8. Does the person to be vaccinated live with or provide care to an infant less than 6 months of age?  |     |    |
| 9. Is the person to be vaccinated between the ages of 6 months and 24 years of age?  |     |    |
| 10. Does the person to be vaccinated have a chronic medical condition such as asthma, chronic obstructive pulmonary disease (COPD), diabetes, kidney, liver or heart disease, etc.?                |     |    |
| 11. Is the person to be vaccinated pregnant?   |     |    |
| 12. Is the person to be vaccinated younger than 24 months of age (2 years)?  |     |    |
| 13. Is the person to be vaccinated 50 years of age or older?   |     |    |
| 14. Has the person to be vaccinated received any of the following live virus vaccines: Influenza A (H1N1), FluMist, MMR (measles, mumps, rubella), or Varicella (chicken pox) in the past 28 days? |     |    |
| 15. Does the person to be vaccinated have a weakened immune system (for example: cancer, lymphoma, leukemia, HIV/AIDS, Lupus, etc.) that makes him/her more likely to contract an infection?       |     |    |
| 16. Is the person to be vaccinated receiving any aspirin-containing therapy?   |     |    |
| 17. Does the person to be vaccinated have an active muscular or neurologic disorder such as cerebral palsy that can lead to breathing or swallowing problems?                                      |     |    |
| 18. Is the person to be vaccinated allergic to gentamicin, gelatin, or arginine?   |     |    |
| 19. Will the person to be vaccinated have taken antiviral medications within 48 hours prior to vaccination?  |     |    |
| 20. Is the person to be vaccinated in close contact with a person who has a severely weakened immune system requiring care in a protected environment such as a bone marrow transplant unit?       |     |    |

I have read the Vaccine Information Statements (VIS) for both Live Attenuated Influenza A (H1N1) Vaccine and Inactivated Influenza A (H1N1) Vaccine or have had the information about these vaccines explained to me. I have had a chance to ask questions that were answered to my satisfaction and believe I understand the benefits and risks of Influenza A (H1N1) vaccine. I understand that the vaccinators will determine the type of Influenza A (H1N1) vaccine to be given based on my responses to the above questions. I consent and request that the vaccine be given to me or the person named on this form for whom I am authorized to make this request. I authorize the Cook County Department of Public Health (CCDPH) and the school or daycare center where the vaccine is administered to retain a record of this vaccination and further authorize these entities to release this form to the CCDPH, for use as permitted by applicable law. I acknowledge receipt of a CCDPH

Notice of Privacy Practices.

PRINT name \_\_\_\_\_ Relationship to person \_\_\_\_\_  
vaccinated: (check one)  Self  Parent/Guardian  Other

Signature of person to receive vaccine or person authorized to make the request on his/her behalf: \_\_\_\_\_

X \_\_\_\_\_ Date: \_\_\_\_\_

### FOR CLINIC USE ONLY

Comments: \_\_\_\_\_

| Date Vaccinated | VIS Date | Manufacturer and Lot # | Site of Administration   | Signature of Vaccine Administrator |
|-----------------|----------|------------------------|--|------------------------------------|
|                 |          |                        | <small>IN=Intranasal<br/>LD=Left deltoid<br/>LT=Left thigh<br/>RD=Right deltoid<br/>RT=Right thigh</small> |                                    |
|                 |          |                        |  |                                    |

**COOK COUNTY DEPARTMENT OF PUBLIC HEALTH  
Vaccination Assistance for Influenza A (H1N1) Vaccine**

| Question Number | Screening Question - YES Response  | Action   |
|-----------------|--|--|
| 1               | Has the person to be vaccinated had an Influenza A (H1N1) vaccination in the past 28 days?   | Do <b>NOT</b> vaccinate.   |
| 2               | Does the person to be vaccinated have a sensitivity/allergy to latex?  | Vaccinate using latex-free gloves.   |
| 3               | Does the person to be vaccinated have a history of Guillain-Barré syndrome?  | Do <b>NOT</b> vaccinate.   |
| 4               | Does the person to be vaccinated have an illness with fever or other active infection?   | Do <b>NOT</b> vaccinate.   |
| 5               | Does the person to be vaccinated have a serious allergy to eggs such as hives or difficulty breathing?   | Do <b>NOT</b> vaccinate.   |
| 6               | Has the person to be vaccinated ever had a serious reaction to an influenza vaccination?   | Do <b>NOT</b> vaccinate.   |
| 7               | Does the person to be vaccinated have a sensitivity/allergy to thimerosal?   | Do <b>NOT</b> use <b>Novartis</b> products. Do <b>NOT</b> use <b>multi-dose vial</b> products.     |
| 8               | Does the person to be vaccinated live with or provide care to an infant less than 6 months of age?   | <b>Vaccinate</b> with appropriate product.   |
| 9               | Is the person to be vaccinated between the ages of 6 months and 24 years of age?   | <b>Vaccinate</b> with appropriate product.   |
| 10              | Does the person to be vaccinated have a chronic medical condition such as asthma, COPD, diabetes, kidney, liver, heart, etc.?  | Do <b>NOT</b> use <b>Live H1N1 (MedImmune)</b> .   |
| 11              | Is the person to be vaccinated pregnant?   | Do <b>NOT</b> use <b>Live H1N1 (MedImmune)</b> .   |
| 12              | Is the person to be vaccinated younger than 24 months of age (2 years)?  | Do <b>NOT</b> use <b>Live H1N1 (MedImmune)</b> , <b>Novartis</b> , or <b>CSL</b> vaccines.         |
| 13              | Is the person to be vaccinated 50 years of age or older?   | Do <b>NOT</b> use <b>Live H1N1 (MedImmune)</b> .   |
| 14              | Has the person to be vaccinated received any of the following live virus vaccines InfluenzaA (H1N1), FluMist, MMR (measles, mumps, rubella), or Varicella (chicken pox) in the past 28 days? | Do <b>NOT</b> use <b>Live H1N1 (MedImmune)</b> .   |
| 15              | Does the person to be vaccinated have a weakened immune system (for example: cancer, lymphoma, leukemia, HIV/AIDS, Lupus, etc.) that makes him/her more likely to contract an infection?     | Do <b>NOT</b> use <b>Live H1N1 (MedImmune)</b> .   |
| 16              | Is the person to be vaccinated receiving any aspirin-containing therapy?   | Do <b>NOT</b> use <b>Live H1N1 (MedImmune)</b> if the person is <b>less than 18 years of age</b> . |
| 17              | Does the person to be vaccinated have an active muscular or neurologic disorder such as cerebral palsy that can lead to breathing or swallowing problems?                                    | Do <b>NOT</b> use <b>Live H1N1 (MedImmune)</b> .   |
| 18              | Is the person to be vaccinated allergic to gentamicin, gelatin, or arginine?   | Do <b>NOT</b> use <b>Live H1N1 (MedImmune)</b> .   |
| 19              | Will the person to be vaccinated have taken antiviral medications within 48 hours prior to vaccination?  | Do <b>NOT</b> use <b>Live H1N1 (MedImmune)</b> .   |
| 20              | Is the person to be vaccinated in close contact with a person who has a severely weakened immune system requiring care in a protected environment such as a bone marrow transplant unit?     | Do <b>NOT</b> use <b>Live H1N1 (MedImmune)</b> .   |