

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

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

*Place Client 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 vaccinator 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 |
|-----------------|----------|------------------------|---|------------------------------------|
|                 |          |                        | IN=Intranasal<br>LD=Left deltoid      RD=Right deltoid<br>LT=Left thigh      RT=Right thigh |                                    |
|                 |          |                        |   |                                    |