

## 2009 H1N1 Influenza Immunization Screening and Consent Form\*

Recipient Name (please print)	Date of Birth	Date of Immunization	
Address	City	State	Zip
Parent/Guardian (if applicable, please print)	Sex	Phone	Campus Wide ID (CWID)
	F   M		
	Health Care Provider's Name <b>MARY L. DUNNE, MD, MEDICAL DIRECTOR</b>		
	Health Care Provider's Address/Phone Number <b>3399 NORTH ROAD, POUGHKEEPSIE, NY 12601 845-575-3270</b>		
Clinic/Office Site Where Vaccine is Administered <b>MARIST COLLEGE HEALTH SERVICES</b>			

<b>Indications</b>	Is this your (your child's) first time getting the 2009 H1N1 (swine) flu vaccine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Are you (your child) between 6 months and 24 years of age?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you work in healthcare or emergency medical services?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	For ages 25 - 64 years, do you have a chronic or immunosuppressive medical condition?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Are you pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Are you a household contact or caregiver for children younger than 6 months of age?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/>	<input type="checkbox"/>
<b>Contraindications</b>	Are you sick with fever today?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever had a serious reaction to the nasal spray or flu shot vaccine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have a severe allergy to eggs, a severe allergy to a component of the vaccine, or a severe allergic reaction (anaphylaxis) allergy to latex?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever had Guillain Barre' Syndrome?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

### Influenza Consent

I have read, or had explained to me, the information sheet about 2009 H1N1 influenza vaccination. I have had a chance to ask questions which were answered to my satisfaction and I understand the benefits and risks of the vaccination as described. I request that 2009 H1N1 influenza vaccination be given to me (or the person named above for whom I am authorized to make this request). I authorize the release of any medical or other information necessary to process a Medicare or other insurance claim or for other public health purpose.

\_\_\_\_\_  
Signature of Recipient (parent or guardian)

\_\_\_\_\_  
Date

### Area Below to be Completed by Vaccinator

Administration Site     Left Deltoid     Right Deltoid     Left Thigh     Right Thigh     Nasal

Dosage                     0.5 ml                                       

VIS Date \_\_\_\_\_                    Manufacturer & Lot Number **SANOBI PASTEUR INFLUENZA A H1N1 MONOVALENT VACCINE**  
UP007AA Expires 16 Mar 2011

I have reviewed side effects with patient (parent or guardian)

Vaccinator Signature \_\_\_\_\_

                                      

**\* Use of this form is optional.**