New York State Department of Health
Bureau of Immunization

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 F M	Phone / Medicare Claim Number
Name of HMO/MCO, If Member	Health Care Provider's Name	
HMO/MCO Policy #, If Known	Health Care Provider's Address/Phone Number	
Clinic/Office Site Where Vaccine is Administered	Mother's Maiden Name: (optional - ?needed for children under age 19?))	

Indications	Is this your (your child's) first time getting the 2009 H1N1 (swine) flu vaccine?	☐ Yes	☐ No
	Are you (your child) between 6 months and 24 years of age?	☐ Yes	☐ No
	Do you work in healthcare or emergency medical services?	☐ Yes	☐ No
	For ages 25 - 64 years, do you have a chronic or immunosuppressive medical condition?	☐ Yes	☐ No
	Are you pregnant?	☐ Yes	☐ No
	Are you a household contact or caregiver for children younger than 6 months of age?	☐ Yes	☐ No
Contraindications	Are you sick with fever today?	☐ Yes	☐ No
	Have you ever had a serious reaction to the nasal spray or flu shot vaccine?	☐ Yes	☐ 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?	☐ Yes	☐ No
	Have you ever had Guillain Barre' Syndrome?	☐ Yes	☐ No
LAIV Contraindications	Do you have close contact with anyone with a severely weakened immune system or are you pregnant?	☐ Yes	☐ No
	For children ages 2 - 4 years, has your child had asthma or wheezing episodes in the last year?	☐ Yes	☐ No
	Is the child or teen to be vaccinated receiving long term aspirin treatment?	☐ Yes	☐ 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 ☐ 0.25ml ☐ LAIV

VIS Date _____ Manufacturer & Lot Number _____

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

Vaccinator Signature _____

Next Immunization Date: ☐ Next Year ☐ In 4 weeks ☐ Other

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