Minnesota 2009 H1N1 Influenza Vaccine

(Injection or Nasal Spray Form)

Information about Individual to Receive Vaccine (Please Print)

NAME (Last)		(First)		(M.I.)
MOTHERS MAIDEN NAME (LAST)			**DATE OF BIRTH** Month_____ Day_____ Year _____	**AGE**
ADDRESS				
CITY	**STATE**	**ZIP**	**DAYTIME PHONE NUMBER:**	

Screening for Vaccine Eligibility

The answers to the following questions will help us to determine if you can get the 2009 H1N1 influenza vaccine. Please mark YES or NO for each question.	**YES**	**NO**
1. Are you ill today?		
2. Do you have a serious allergy to eggs?		
3. Do you have any other serious allergies? Please list: _____		
4. Have you ever had a serious reaction to a previous dose of influenza vaccine?		
5. Have you ever had Guillain-Barré Syndrome? (Guillain-Barré Syndrome is a type of temporary severe muscle weakness)		

Your answers to the following questions will help us know which type of vaccine you can receive. (Injection or Nasal Spray)	**YES**	**NO**
1. Have you gotten vaccinated with any vaccine (not just flu) within the past 30 days? Vaccine: _____ Date given: Month_____Day_____Year_____		
2. Do you have any of the following: Asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood?		
3. Are you on long-term aspirin or aspirin-containing therapy? (For example, do you take an aspirin every day?)		
4. Do you have a weak immune system? (For example, from HIV, cancer, or medications such as steroids or those used to treat cancer)?		
5. Are you pregnant?		
6. Do you have close contact with a person who is hospitalized and in a protected environment? (For example, a hospitalized person who has had a bone marrow transplant)		
7. Are you or have you been on an antiviral medication within the last 48 hours?		
8. Is the person to be vaccinated younger than 2 years old or 50 years or older?		

CONSENT FOR VACCINATION:

I GIVE CONSENT to be vaccinated with the 2009 H1N1 vaccine. I have received the 2009-2010 Vaccine Information Statement for the 2009 H1N1 influenza vaccine and understand the risks and benefits.

I understand that the information contained within this record is being maintained to monitor immunization needs in order to prevent disease. This information is confidential and will only be shared with organizations or persons who are authorized by law to receive it. This includes the Minnesota Department of Health, a health care provider or health care organization providing services on behalf of the child, the child's school or childcare and anyone else authorized under law to receive it. This information will be included in the Minnesota Immunization Information Connection Registry, a secure web-based registry system for health care providers. If you choose not to have your child's information shared with registry please call 1-800-657-3970.

Signature of person receiving vaccine or Parent/Legal Guardian:

Sign: _____ **Date:** _____

(Vaccination will not be administered if this consent form is not signed and dated.)

FOR ADMINISTRATIVE USE ONLY

Vaccine	**Date Administered/ VIS Given**	**Route**	**Dose**	**Injection Site**	**Vaccine Manufacturer**	**Lot Number**
2009 H1N1	/ /	IM Intranasal	0.25 ml 0.5 ml 0.2 ml			
Name and Title of Vaccine Administrator						