



Hoboken Health Department
 124 Grand Street
 Hoboken, NJ 07030
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2009 H1N1 INFLUENZA VACCINE CONSENT FORM
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Section 1: Information about Child/Adult to Receive Vaccine (please print)

VACCINE RECIPIENT NAME (Last)	(First)	(M.I.)	DATE OF BIRTH	
PARENT/LEGAL GUARDIAN'S NAME (Last)	(First)	(M.I.)	month day year	GENDER
ADDRESS			AGE _____	M / F
CITY STATE ZIP			DAYTIME PHONE NUMBER: ()	
SCHOOL/ DAYCARE NAME			Email: _____	
			GRADE	

Section 2: Screening for Vaccine Eligibility

If your child has already been vaccinated with 2009 H1N1 influenza vaccine, please tell us the number of doses and dates of vaccination.

- | | | | | |
|---------------------------------|---|-----------------------|-------------|-----------|
| <input type="checkbox"/> Dose 1 | Date received: month ____ day ____ year _____ | Form (please circle): | Nasal spray | Injection |
| <input type="checkbox"/> Dose 2 | Date received: month ____ day ____ year _____ | Form (please circle): | Nasal spray | Injection |

The following questions will help us to know if recipient can get the 2009 H1N1 influenza vaccine. Please mark YES or NO for each question.

A. If you answer "NO" to all four of the following questions, the recipient can probably get the influenza vaccine. If you answer "YES" to one or more of the following four questions, the recipient may be able to get the 2009 H1N1 vaccine, but we will discuss your options.

	YES	NO
1. Does the individual receiving the vaccine have a serious allergy to eggs?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the individual receiving the vaccine have any other serious allergies? <i>Please list:</i> _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the individual receiving the vaccine ever had a serious reaction to a previous dose of flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the individual receiving the vaccine ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you allergic to Latex?	<input type="checkbox"/>	<input type="checkbox"/>
6. Has the individual receiving the vaccine gotten vaccinated with any other vaccine (not just flu) within the past 30 days? <i>Vaccine:</i> _____	<input type="checkbox"/>	<input type="checkbox"/>
7.) Have you received a bone marrow transplant or received chemotherapy within the past 60 days?	<input type="checkbox"/>	<input type="checkbox"/>

(Please Complete both sides of the form)

Section 3: Consent

CONSENT FOR VACCINATION:

I have read or had explained to me the 2009-2010 Vaccine Information Statement for the 2009 H1N1 influenza vaccine and understand the risks and benefits. I accept responsibility for seeking medical attention for any problems with this vaccination.

I understand that if my child is under 10 years of age, two doses of the H1N1 influenza vaccine are required. Each dose will be administered approximately one month apart. I give consent for my child to receive two doses of the H1N1 vaccine, each dose spaced about 21 to 28 days apart.

I GIVE CONSENT to the HOBOKEN HEALTH DEPARTMENT and its vaccination staff for myself or my child named at the top of this form to be vaccinated with the 2009 H1N1 influenza vaccine.

Signature of Vaccine recipient (if 18 years of age or older)

or

Parent/Legal Guardian Signature _____

Date: month _____ day _____ year _____

Section 4: Permission to Release Information

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 New Jersey Department of Health and Senior Services, Hoboken Health Department, a health care provider or health care organization providing treatment or health care services on behalf of an individual or on behalf of a child, a child's school or childcare and anyone else authorized under law to receive it. *(If this consent form is not signed, dated, and returned, then the person named above will not be vaccinated)*

Signature of Vaccine recipient (if 18 years of age or older)

or

Parent/Legal Guardian Signature _____

Date: month _____ day _____ year _____

FOR ADMINISTRATIVE USE ONLY

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Vaccine	Date Dose Administered	Route/Site	Staff Initial	Dose Number (1st or 2nd)	Vaccine Manufacturer	Lot Number
2009 H1N1	/ /2010	IM <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Arm <input type="checkbox"/> Leg			Pre-filled (.25) <input type="checkbox"/> Sanofi - # UT029BA <input type="checkbox"/> Sanofi - # UT030FA Pre-filled (.5) <input type="checkbox"/> Sanofi - # UP034BB <input type="checkbox"/> Sanofi - # UP049CA <input type="checkbox"/> Sanofi - # UP035BA <input type="checkbox"/> Sanofi - # UT040BA	MDV (5mL) <input type="checkbox"/> Novartis - #102125P1 <input type="checkbox"/> Novartis - #102147P1 <input type="checkbox"/> Novartis - #102145P1 Pre-filled (.5) <input type="checkbox"/> Novartis - #1008131P
					Pre-filled (.5) <input type="checkbox"/> CSL - #00349611A <input type="checkbox"/> CSL - #00949611A <input type="checkbox"/> CSL - #L30311	MDV (5mL) <input type="checkbox"/> Sanofi - #UP066AA <input type="checkbox"/> Sanofi - # UP068AA

Check the vaccine priority group this individual fits into:

- Pregnant woman
- Person that lives with or cares for an infant younger than 6 months of age
- Healthcare or emergency medical personnel
- 6 months – 24 years of age
- 25 – 64 years of age with chronic health disorders or compromised immune systems