New York State Department of Health
Bureau of Immunization

2009 H1N1 Influenza Immunization Screening and Consent Form

Name (please print)	Date of Birth	Age	Date of Immunization
Address Zip	City		State
Parent/Guardian (please print)	Sex F M	Patient Phone	Medicare Claim Number
Name of HMO/MCO, If Member	Provider's Name		
HMO/MCO Policy #, If Known	Provider's Address		
Clinic/Office Site Where Vaccine is Administered	Mother's Maiden Name: (optional)		

Indications	Have you (your child) had any vaccine within the last 28 days, including the 2009 H1N1 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 anaphylactic 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 this child had asthma or wheezing episodes in the last year?	☐ Yes	☐ No
	Is this child or teen to be vaccinated receiving long term aspirin treatment?	☐ Yes	☐ No
	Have you recently or are you now taking antiviral medications?	☐ Yes	☐ No

Influenza Consent

I have read, or had explained to me, the Vaccine Information Sheet (VIS) 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