

Please complete and return this form (PLEASE PRINT).

Name receiving vaccination: _____ Birth date (mm/dd/yyyy): _____
 Address: _____ City: _____ State: _____ Zip Code: _____
 Home/Cell telephone: _____ Emergency contact number: _____
 If vaccine is being administered to a child under the age of 18 years:
 Parent/Legal Guardian: _____

Please circle YES or NO to all of the questions below:

1. Are you (or if completing for your child) allergic to eggs, egg proteins, or to another component of influenza vaccines, such as arginine, gelatin, gentamicin (antibiotic) neomycin (antibiotic) and polymyxin (antibiotic)?	Yes	No
2. Have you (or if completing for your child) ever had a serious reaction to an influenza vaccine?	Yes	No
3. Have you (or if completing for your child) ever had Guillain-Baré syndrome?	Yes	No
4. Do you (or if completing for your child) have asthma or recurrent or active wheezing?	Yes	No
5. Have you (or if completing for your child) received a vaccine within the past 30 days? If yes, please list name of vaccine(s): _____ Date _____	Yes	No
6. Have you taken any antiviral medications (Tamiflu or Relenza) in the past 48 hours?	Yes	No
7. If completing for your child under 18 years, is he/she currently receiving aspirin or aspirin containing therapy?	Yes	No N/A
8. Do you (or if completing for your child) have any diseases (e.g., cancer, lupus, or human immunodeficiency virus [HIV] or acquired immunodeficiency syndrome [AIDS]) or take a medication (e.g., steroids or chemotherapy) that lowers the body's resistance to infection?	Yes	No
9. Do you have any of the following health problems? If yes, please check: <input type="checkbox"/> Heart disease <input type="checkbox"/> lung disease <input type="checkbox"/> kidney disease <input type="checkbox"/> diabetes <input type="checkbox"/> other _____	Yes	No
10. Are you pregnant or nursing?	Yes	No
11. The Acting Physician General of the Commonwealth has delegated to qualified paramedics the function of administering H1N1 influenza vaccine in approved vaccination clinics. Do you agree that you or your child may have a paramedic administer the H1N1 vaccine?	Yes	No

I have been given the Centers for Disease Control and Prevention Vaccine Information Statement (VIS). I have read the VIS and have no further questions at this time. I understand the risks and benefits of H1N1 influenza vaccine. I request and voluntarily consent that H1N1 influenza vaccine be given to _____ (self or name of child of whom I am the Parent/Legal Guardian), and I acknowledge that no guarantees have been made concerning the vaccine's success. I understand the possible side effects and warnings and precautions that should be taken into consideration prior to administration of the vaccine.

My preference for me or my child's influenza vaccine is the following:

- Inactivated injectable influenza vaccine (shot in the arm, shot in leg for infant) ONLY**
- Live intranasal influenza vaccine (spray in the nose) ONLY**
- Either injectable influenza vaccine OR live intranasal influenza vaccine**

Name of self or Parent/Legal Guardian: _____ Date: _____

Signature of Parent/Legal Guardian: _____ Date: _____

For children younger than the date of their 10th birthday:

Your second dose of H1N1 vaccine should be given after this date: _____

For Staff use only:

Vaccine	Date Administered	Route	Dose Number (1 st or 2 nd)	Vaccine Manufacturer	Lot Number	Site/Dosage	Signature of Vaccinator
2009 H1N1	/ /	<input type="checkbox"/> IM <input type="checkbox"/> Intranasal					