



ADULT (18 YEARS OR OLDER) - 2009 H1N1 INFLUENZA VACCINATION CONSENT FORM

SECTION A: CLIENT INFORMATION			
Name (Last, First, Middle) :			
Date of Birth: / /	Age:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	
School:	Position:		
SECTION B: CONTACT INFORMATION			
Name (Last, First, Middle) :			
Address:		City/State:	Zip:
Phone:	Home:	Work:	Cell:
SECTION C: SCREENING FOR VACCINE ELIGIBILITY			
If you have already been vaccinated with 2009 H1N1 influenza vaccine , please tell us the dates of vaccination.			
Date received: month _____ day _____ year _____ Form (please circle): nasal spray shot			
SECTION D: CLIENT HEALTH HISTORY			
The following questions will help us know if you can get the 2009 H1N1 influenza vaccine. Please mark either Yes or No for each question. Do not leave any question unanswered.			
If you answer "NO" to all of the following questions, you can probably get the influenza vaccine. If you answer "YES" to one or more of the following questions, you <u>may</u> be able to get the H1N1 vaccine, but we will contact you to discuss your options.			
	<u>Yes</u>	<u>No</u>	
1. Have you ever had a serious allergic reaction to eggs or the antibiotic gentamicin?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Have you ever had a serious reaction to a previous dose of seasonal flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Have you ever had Guillain-Barré syndrome (GBS), (i.e. paralysis) within 6 weeks after receiving a flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Are you taking any prescription medication to prevent or treat flu?	<input type="checkbox"/>	<input type="checkbox"/>	
*5. Do you have any other serious allergies that you know of? Please list: _____	<input type="checkbox"/>	<input type="checkbox"/>	
If answered Yes to any questions (1-5) ⇒ Medical Screening			
6. Are you taking any prescription medication to prevent or treat flu?	<input type="checkbox"/>	<input type="checkbox"/>	
7. Do you have asthma, wheezing, difficulty breathing, or lung disease?	<input type="checkbox"/>	<input type="checkbox"/>	
8. Do you have a long-term health problem such as heart disease, kidney disease, metabolic disease (e.g., diabetes), or blood disorders (e.g., anemia)?	<input type="checkbox"/>	<input type="checkbox"/>	
9. Do you have a weakened immune system caused by cancer, cancer treatment (e.g., x-rays or drugs), HIV/AIDS, other disorders, or medicine (e.g. steroids)?	<input type="checkbox"/>	<input type="checkbox"/>	
10. Do you live with or have a close contact with anyone with a severely weakened immune system requiring care in a protected environment (such as a hospitalized family member receiving chemotherapy)?	<input type="checkbox"/>	<input type="checkbox"/>	
11. Are you 18 years old or younger AND taking aspirin or other aspirin-containing therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
12. Have you received an MMR (measles/mumps/rubella), varicella (chickenpox), or the live intranasal seasonal influenza vaccine (LAIV) within the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	
13. Do you have a muscle or nerve disorder (such as cerebral palsy) that can lead to breathing or swallowing problems?	<input type="checkbox"/>	<input type="checkbox"/>	
14. Are you pregnant or nursing?	<input type="checkbox"/>	<input type="checkbox"/>	
15. Are you 50 years or older?	<input type="checkbox"/>	<input type="checkbox"/>	
If answered Yes to any questions (6-15) ⇒ NO LAIV			
SECTION E: CONSENT FOR VACCINATION			
I have read the 2009 H1N1 Influenza CDC Vaccination Information Statements (VIS) for the H1N1 influenza shot and for the nasal spray. I understand the risks and benefits, and give consent to the Health Department and its authorized staff to vaccinate me with this vaccine.			
Signature of Client: _____			Date: ____ / ____ / ____

SECTION F: OFFICE OF PRIVACY AND SECURITY
Authorization for Disclosure of Protected Health Information

As the person signing this authorization, I understand that I am giving permission to the Virginia Department of Health (VDH) to disclose personal health information to the person(s) or organization(s) indicated below.

- I understand the provision of treatment cannot be conditioned on my signing of this Authorization for Disclosure Section.
- Any health information re-disclosed by you will no longer be protected by this authorization.
- The original or a copy of the authorization shall be included in my medical record.
- I have the right to revoke this authorization at any time, except to the extent that action has been taken prior to my request to withhold my medical record. The request must be in writing and will be effective upon delivery to the provider in possession of my medical records.
- I authorize VDH to disclose my health information to my primary care physician.
- I understand that this record will be retained for ten years after the last visit or for five years after age 18, whichever comes later.
- I understand this document will be given to and retained by the public health department and will not be maintained by the school.

SECTION G: NOTICE OF DEEMED CONSENT
(Required by §32.1-45.1 of the Code of Virginia (1950), as amended)

If the health care provider or the person acting under the health care provider's direction and control is directly exposed to my blood in a way that may transmit disease, I understand that the law requires me to give a venous blood sample for further tests. I understand that the tests to be performed are for human immunodeficiency virus (HIV), hepatitis and/or other infectious diseases and that a physician or health care provider will inform me and the exposed provider of the results of the test.

I understand that the Virginia Department of Health will not release private medical records unless authorized above or to continue care.

Please Print Your Name

Signature

Date

Provider Signature: _____ Date: ____/____/____