

**Polk County Health Department**  
**2009 H1N1 Influenza Vaccine Adult Consent Form**  
 Intranasal or Intramuscular

NAME (Last)		(First)	(M.I.)	DATE OF BIRTH month _____ day _____ year _____	
ADDRESS				AGE	PHONE
CITY	STATE	ZIP	GENDER M / F		

**Please answer the following questions by circling "YES" or "NO".**

1. Do you have a serious allergy to eggs?	YES	NO
2. Do you have any other serious allergies? Please list: _____	YES	NO
3. Have you ever had a serious reaction to a previous dose of flu vaccine?	YES	NO
4. Have you ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	YES	NO

**There are two kinds of 2009 H1N1 influenza vaccine. Your answers to the following questions will help us know which of the two kinds of vaccine you can get. (Please circle "YES" or "NO")**

1. Have you been vaccinated with any vaccine (not just flu) within the past 30 days? If yes, please indicate type and date. Vaccine: _____ Date given: month _____ day _____ year _____	YES	NO
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?	YES	NO
3. Is your child on long-term aspirin or aspirin-containing therapy (for example, does your child take aspirin every day)?	YES	NO
4. Do you have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)?	YES	NO
5. Are you pregnant?	YES	NO
6. Do you have close contact with a person who needs care in a protected environment (for example, someone who has recently had bone marrow transplant)?	YES	NO
7. Do you prefer to get one type of vaccine over another? If "YES" check which kind of vaccine below that you want to have. You may not receive this preferred vaccine if you have a medical contraindication or if that vaccine is unavailable. _____ Flu Mist (intranasal) _____ Inject able ( Intramuscular)	YES	NO

**Please circle "YES" or "NO" for each consent item and sign below.**

1. 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. This consent allows for the Polk County Health Department to administer H1N1 vaccine to me.	YES	NO
2. I consent to sharing H1N1 Immunization Data with the Wisconsin Immunization Registry (WIR):	YES	NO
3. If you are covered by health insurance, I consent to allow the Polk County Health Department to bill my private insurance company for an administration fee.	YES	NO
Insurance Company Name: _____ Mailing Address: _____ _____ City: _____ State: _____ Zip: _____ Group #: _____ ID #: _____ Subscriber Name: _____ BadgerCare ID Number (if applicable): _____		

**Signature: \_\_\_\_\_ Date: \_\_\_\_\_**

**FOR ADMINISTRATIVE USE ONLY**

Dose	Date Dose Administered	Route	IM Site	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator
1		<input type="checkbox"/> IM <input type="checkbox"/> Intranasal	<input type="checkbox"/> LD <input type="checkbox"/> RD			