MORRIS COUNTY
2009-10 H1N1 NASAL SPRAY Vaccine Consent Form

Nasal Spray is for people age 2 – 49 years ONLY

Section 1: Information about person receiving vaccine (PLEASE PRINT)

NAME (Last)	(First)	(M.I.)	**DATE OF BIRTH** month_____ day_____ year _____
ADDRESS			**GENDER** MALE _____ FEMALE _____
CITY	**STATE**	**ZIP**	**PHONE #**

Section 2: Screening for Nasal Vaccine Eligibility

	YES	**NO**
1. Have you received a vaccine within the past 30 days or will you in the next 30 days? If yes, please list name of vaccine(s):		
2. Have you received a flu or flu mist vaccination before?		
3. Are you sick today?		
4. Are you allergic to any part of the vaccine (eggs, egg proteins, gentamicin, gelatin, arginine or MSG)?		
5. Have you ever had a life-threatening reaction to an influenza vaccine?		
6. If you are age 2-17, are you currently take aspirin or aspirin-containing therapy?		
7. Do you have asthma, recurrent wheezing (only relevant to children under 5 years of age), or active wheezing? Have you used an inhaler in the last 12 months?		
8. Have you ever had Guillain-Barré syndrome? Or active neurological disorders?		
9. Do you have any diseases (for example, cancer, lupus, or HIV/AIDS) or take a medication (for example, steroids or chemotherapy) that lowers the body's resistance to infection?		
10. Are you pregnant or nursing?		
11. Do you have any of the following long-term health problems? (CIRCLE) heart disease kidney disease metabolic diseases (for example, diabetes) liver disease lung disease anemia or other blood disorder other_____		
12. Does the person being vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (such as in a hospital room with reverse air flow)?		

Section 3: Consent for Vaccination

H1N1 VACCINE CONSENT

I have been given the 2009-10 H1N1 CDC Vaccine Information Statement. I have had the opportunity to ask questions that have been answered to my satisfaction. I believe I understand the benefits and risks of the H1N1 vaccine and I request and consent that it be given to me or to the person named of whom I am parent, guardian or authorized person. I release the health department from any responsibility for my own health care needs, or liability from health consequences that may occur from my participation in this program. I also consent to having this data recorded in NJIIS (New Jersey Immunization Information System).

Signature: _____ Date: _____

FOR ADMINISTRATIVE USE ONLY

Vaccine	**Date Dose Administered**	**Dose # 1 or 2***	**Vaccine Manufacturer**	**Lot Number**	**Staff Signature**
2009 H1N1			MedImmune		

*As of 10/8/2009, two (2) doses of H1N1 vaccine are required for children 6 months through 9 years of age