H1N1 Flu Vaccine Consent Form --Injectable Flu Shot <u>or</u> Nasal Spray Vaccines

Section 1: Information about Person to Receive Vaccine (please print)

NAME of person receiving vaccine (Last)		(First)	(M.I.)	**DATE OF BIRTH of person receiving vaccine** / /	
If Child PARENT/LEGAL GUARDIAN'S NAME (Last)		(First)	(M.I.)	**AGE of person receiving vaccine**	**GENDER of person receiving vaccine** M / F
ADDRESS				**If child PARENT/GUARDIAN DAYTIME PHONE NUMBER:**	
CITY	**STATE**	**ZIP**			

Section 2: Screening for Vaccine Eligibility

If the person receiving vaccine has already been vaccinated with 2009 H1N1 flu vaccine, please tell us the number of doses and dates of vaccination.

☐ Dose 1 Date received: month ____day____year_______ Form (please circle): nasal spray shot
☐ Dose 2 Date received: month ____day____year_______ Form (please circle): nasal spray shot

The following questions will help us to know if the person receiving vaccine can get the 2009 H1N1 flu vaccine. Please mark YES or NO for each question.

A. If you answer "YES" to one or more of the four questions, you will not be able to receive the 2009 H1N1 flu vaccine unless there is a note from your health care provider approving the vaccination. If you answer "NO" to the following questions you will receive the vaccine unless a concern arises following additional screening. If you are not sure of the answers to these questions, please check with your healthcare provider.

1. Does the person receiving vaccine have a fever	**YES**	**NO**
2. Does the person receiving vaccine have a serious allergy to eggs?	☐	☐
3. Does the person receiving vaccine have a serious allergy to gentamicin, neomycin, polymixin or gelatin?	☐	☐
4. Has the person receiving vaccine ever had a serious reaction to a previous dose of flu vaccine?	☐	☐
5. Has the person receiving vaccine ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	☐	☐

B. There are two kinds of 2009 H1N1 flu vaccine. Your answers to the following questions will help us determine if you are able to receive the nasal spray vaccine.

1. Does the person receiving vaccine have a fever?	**YES**	**NO**
2. Has the person receiving vaccine been vaccinated with any vaccine (not just flu) within the past 30 days? Vaccine: ____________________ Date given: month______day________	☐	☐
3. Does the person receiving vaccine have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood?	☐	☐
4. If the person receiving vaccine is 2-4 years of age, has a healthcare provider told you that your child had wheezing or asthma within the last 12 months?	☐	☐
5. Is the person receiving vaccine on long-term aspirin or aspirin-containing therapy (for example, does your child take aspirin every day)?	☐	☐
6. Does the person receiving vaccine have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)?	☐	☐
7. Is the person receiving vaccine pregnant?	☐	☐
8. Does the person receiving vaccine have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?	☐	☐

List other serious allergies: ____

Section 3: Consent

CONSENT FOR VACCINATION: I have read or had explained to me the 2009-2010 Vaccine Information Statement for the H1N1 influenza vaccine and understand the risks and benefits.	
I GIVE CONSENT for my child or myself named at the top of this form to get vaccinated with this vaccine. Children younger than 10 years of age need 2 doses of vaccine. (If this consent is not signed, then my child will not be vaccinated.) Signature of Person receiving vaccine or Parent/Legal Guardian ____________________________________ Date: month _______ day _______ year _______	

<u>PLEASE BE SURE TO READ AND SIGN THE REVERSE SIDE OF THIS FORM</u>

Section 4: Permission to Share Information:

I, ________________________________, give permission to the individual and/or entity that administered the 2009
(Print your name)
H1N1 vaccine to myself or my child __________________________________ to share copies of the 2009 H1N1 consent
(Print full name)
form and vaccination record with my child's school (if applicable) and my or my child's health care provider named below, as well as with the Massachusetts Department of Public Health and the local board of health in my community. I also give permission for each of these entities to share the 2009 H1N1 consent form and vaccination record with each other.

My or my child's health care provider:
Name: ____________________________________
Address: __________________________________

My child's school (if applicable)
Name: ______________________________________
Address: ____________________________________
(at a minimum include Town)

- This health information is disclosed at my request and to ensure that my child or myself is appropriately vaccinated.
- This permission expires one year from the signature date.
- If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information received may no longer be protected by federal privacy regulations. State privacy regulations cover information received by the MA Department of Public Health and local boards of health.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my or my child's ability to obtain the vaccination.
- I understand that I may inspect or copy the protected health information to be disclosed under this permission to share.
- Finally, I understand that I may withdraw this permission in writing at any time by sending written notification to:

____
(School/institution/individuals handling withdrawals MUST insert name and address)

However, if I withdraw permission at a later date, any vaccine consent form and vaccine record already shared will not be covered by the withdrawal.

____ ____________________________________
Printed name of Person receiving vaccine or Parent/ Guardian Signature

____ ____________________________________
Address Date

2009-2010 Vaccine Administration Record

Information about the person to receive vaccine (please print): *Required Fields

Name: (Last, First, MI)*	DOB: (MM/DD/YY)*	Sex: (Circle)* M F
Address:*		

City:*	State:*	Zip:*	Phone:* ( )

INSURANCE INFORMATION: *Include the prefix and suffix with the insurance ID number, if applicable.*

Insurance Company:*	Member ID #:*	Group ID #:

If Patient is not the Subscriber, please complete the following:

Subscriber's Name: (Last, First, MI)*	Subscriber's DOB:	Sex: (Circle)* M F
Subscriber's Address:* (If different from address above)		

City:*	State:*	Zip: *	Phone:* ( )
Patient Relationship to Subscriber:* (Circle)	Spouse	Child	Other

OTHER INSURANCE INFORMATION: *Include the prefix and suffix with the insurance ID number, if applicable.*

Insurance Company:*	Member ID #:*	Group ID #:

I give permission for my insurance company to be billed.

X____ **Date: ________________**

(Signature of patient, parent or legal guardian)

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For Clinic/Office Use: **Contact Person:** ________________________________ **Phone Number:** ______________

Vaccine Name:* (Circle)	Vaccine Manufacturer:	Vaccine Lot Number:	Date Vaccine Administered:*	Vaccine Type:* (Circle)	Injection Site: * (Circle)	Injection Route:* (Circle)
H1N1 Seasonal Influenza			(MM/DD/YY)	Dose #1 Dose #2	Right Arm Left Arm Right Leg Left Leg	Intramuscular Intranasal

Clinic Site Name:______________________________ **Site PIN# :** ______________________

Clinic Address: ______________________________ **Vaccine Administrator:** ______________________

Date Vaccine Information Statement (VIS) given: ____________________ **Date on VIS:** ______________

Signature of Vaccine Administrator: ______________________________ **Date:** ______________

SAMPLE

PERMISSION TO SHARE H1N1 VACCINE INFORMATION

I, _________________________________, give permission to the individual and/or entity that
(Print your name)
administered the 2009H1N1 vaccine to myself or my child _______________________to share
(Print full name)
copies of the 2009 H1N1 vaccination record with my child's school and health care provider named below, as well as with the Massachusetts Department of Public Health and the local board of health in my community. I also give permission for each of these entities to share the 2009 H1N1 vaccination record with each other.

My or my child's health care provider:
Name: ___________________________
Address: _________________________

My child's school (if applicable)
Name: ____
Address: ____
(at a minimum include Town)

- This health information is disclosed at my request and to ensure my child is appropriately vaccinated.
- This permission expires one year from the signature date.
- If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information received may no longer be protected by federal privacy regulations. State privacy regulations cover information received by the MA Department of Public Health and local boards of health.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my child's ability to obtain the vaccination.
- I understand that I may inspect or copy the protected health information to be disclosed under this permission to share.
- Finally, I understand that I may withdraw this permission in writing at any time by sending written notification to:

____

(School/institution/individuals handling withdrawals MUST insert name and address above.)

However, if I withdraw permission at a later date, any vaccine record already shared will not be covered by the withdrawal.

______________________________________ ______________________________________
Printed name of Person receiving vaccine or Parent/ Guardian Signature

______________________________________ ______________________________________
Address Date

Permission to share is compliant with HIPAA and FERPA requirements for billing and sharing purposes.

October 5, 2009