Stephen M. Sweeney
Freeholder Director

Jean DuBois
Freeholder Liaison

Gloucester County
Department of Health
and Senior Services

Division of Health

2009 H1N1 Injectable Influenza Vaccine Consent Form

SECTION 1: INFORMATION ABOUT PERSON RECEIVING VACCINE (PLEASE PRINT)

NAME (Last)	(First)	(M.I.)	**DATE OF BIRTH** _______ / _______ / _______ month / day / year
MAILING ADDRESS			**GENDER** ☐ **MALE** ☐ **FEMALE**
CITY	**STATE**		**ZIP**

SECTION 2: SCREENING FOR *INJECTABLE* VACCINE ELIGIBILITY ONLY

The following questions will help us to know if the person named above can get the 2009 H1N1 influenza vaccine. Please mark YES or NO for each question. Individuals with vaccine or egg allergies may need to consult their physician before getting the vaccine.

		YES	**NO**
1.	Has the person named above ***EVER*** had any type of flu vaccine?	☐	☐
2.	Is the person to be vaccinated sick today with a fever over 100°?	☐	☐
3.	Does the person named above have a serious allergy to eggs, vaccine components or the flu vaccine?	☐	☐
4.	Has the person named above ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	☐	☐

SECTION 3: CONSENT FOR VACCINATION

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. I understand that H1N1 influenza vaccine may contain preservatives.

I GIVE CONSENT to the Gloucester County Department of Health and Senior Services and associated staff to administer this vaccine to me or, if the name appearing above is a minor, to this individual as his/her parent/legal guardian. I understand that the information contained within this record is being maintained to monitor immunization needs in order to prevent disease. This information is confidential and will only be shared with organizations or persons who are authorized by law to receive it. This includes the New Jersey Department of Health and Senior Services, a health care provider or health care organization providing treatment or health care services on behalf of an individual or on behalf of a child, a child's school or childcare and anyone else authorized under law to receive it. ***(If this consent form is not signed & dated, then the person named above will not be vaccinated)***

Signature (if under 18, then legal guardian signature): ____

Print Name (if signed by a legal guardian)____Date: ____________

FOR ADMINISTRATIVE USE ONLY

Vaccine	**Date Dose Administered**	**Route/Site**	**Staff Initial**	**Dose Number**	**Vaccine Manufacturer**	**Lot Number**
2009 H1N1		IM ☐R ☐L ☐Arm ☐Leg			Novartis	102138P1A Exp 3/31/2010

Updated December 9, 2009