

IM Only

**Miami-Dade County Health Department  
2009 H1N1 Influenza Vaccine Consent Form (For Adults)**

For you to be eligible to receive the H1N1 Influenza vaccine, **you must answer all questions and sign this consent form**. Depending on your answers and the availability of the vaccine, you will receive the injectable vaccine. Please read the vaccine information statement we have provided for you.

**Section 1: Demographic Information (please print)**

NAME (Last)		(First)	(M.I.)	DATE OF BIRTH Month _____ Day _____ Year _____	
RACE		SOCIAL SECURITY (OPTIONAL)			
ADDRESS			AGE	GENDER Male or Female	
CITY / COUNTY	STATE	ZIP	PHONE NUMBER		

**Section 2: Screening for Vaccine Eligibility**

If you have already been vaccinated with 2009 H1N1 influenza vaccine, please tell us the 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 you can get the 2009 H1N1 influenza vaccine.

Please mark YES or NO. If you answer "NO" to all 4 of the following questions, you can probably get the H1N1 influenza vaccine. If you answer "YES" to 1 or more of the following questions, you will be screened to determine your eligibility.

Please check Yes or No for each question.	YES	NO
1. Do you have an allergy to eggs?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have any other allergies? Please list _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had a reaction to a previous dose of flu vaccine or to any other type of vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>

**Section 3: Consent**

**CONSENT FOR 2009 H1N1 INFLUENZA VACCINATION:**

I have read the 2009-2010 Vaccine Information Statement for the 2009 H1N1 influenza vaccine and understand the risks and benefits.

I GIVE CONSENT to be vaccinated with the 2009 H1N1 influenza vaccine.

Signature \_\_\_\_\_ Date: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**FOR ADMINISTRATIVE USE ONLY**

Vaccine	Date Dose Administered	Route	Dose Number (1st or 2nd)	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator
2009 H1N1	/ /	<input type="checkbox"/> IM -P <input type="checkbox"/> IM -PF				
2009 H1N1	/ /	<input type="checkbox"/> IM -P <input type="checkbox"/> IM -PF				

