



Division of Disease Control



Bureau of Immunization

Novel H1N1 Vaccine Consent Form

To be used only when consenting for **self**

I have received, read, and understand the **Novel H1N1 Vaccine Information Statement (VIS)**.

I have had a chance to ask questions and discuss my concerns with a healthcare professional.

Information about person to receive vaccine (Please Print)

Name: _____
Last *First* *Middle Initial*

DOB: _____ Gender: _____ Work Site / School Site: _____
(M or F)

Address: _____
Street *City*

_____ *County* *State* *Zip*

Telephone #: _____ Cell #: _____

(Please check one)

- 1. Have you ever had an allergic reaction to flu vaccine? Yes No
- 2. Are you allergic to eggs, or egg products? Yes No
- 3. Do you have a history of Guillain-Barre Syndrome?
(illness associated with the swine flu in 1976 characterized by fever,
nerve damage, and muscle weakness) Yes No
- 4. Are you allergic to thimerosal (a mercury-based preservative)? Yes No
- 5. Are you allergic to latex? Yes No
- 6. Do you feel ill today or have a fever? Yes No

I, _____, ((please print name), consent to receive the Novel H1N1 vaccine.

Signature

Date

For Office Use Only

Date of Vaccination Vaccine Manufacturer Lot Number

Site of Injection: R / L Deltoid

Administered By Title