

2009 H1N1 Intranasal 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 <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
CITY	STATE		ZIP
COUNTY	MUNICIPALITY		PHONE #

SECTION 2: SCREENING FOR INTRANASAL VACCINE ELIGIBILITY*

Please complete the questionnaire found on the reverse side of this consent form.

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 GIVE CONSENT to the STATE/LOCAL health department/healthcare provider 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, and returned, then the person named above will not be vaccinated.)*

Signature of Vaccinee/Parent/Legal Guardian: _____

Vaccinee/Parent/Legal Guardian (Print): _____

Date: _____

Witness to Signature: _____

FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Intranasal Dose Administered	Staff Initial	Dose Number (1st or 2nd)	Vaccine Manufacturer	Lot Number
2009 H1N1					
2009 H1N1					