17043

# Colorado 2009-2010 H1N1 Flu Vaccine Consent and Screening Form

**ADULT**

*Please print neatly in capital letters as shown in the example:* EXAMPLE 123

*Please shade circles completely* Correct: ● Incorrect: ⊠ ✓

*Please use reverse side for notes*

**Personal Information:** Provide information as completely as you can. All information will be kept confidential.

**First Name** | **Last Name** | **MI**

**Street No. or PO Box** | **Street Name** | **Apt. Number**

**City** | **County** | **State** | **Zip Code** | **Gender** O M O F

**Health Insurance:**

O Medicaid O Medicare O Other Private O No Insurance | O Kaiser Permanente

**KAISER Insurance Policy Number:**

**Phone:** ___ - ___ - ____

**Date of Birth:** MM / DD / YYYY

**Race/Ethnicity:** (Fill in all that apply)

O Asian O Native Hawaiian/Pacific Islander O Hispanic/Latino O Other
O Black, African American O American Indian/Alaskan Native O White

| | |
|---|---|
| 1. Are you sick today? | O YES O NO |
| 2. Do you have a serious allergy to eggs or to a component of the flu vaccine? | O YES O NO |
| 3. Have you ever had a serious reaction to a previous dose of flu vaccine? | O YES O NO |
| 4. Have you ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness)? | O YES O NO |
| 5. Are you pregnant, or is there a chance you may become pregnant in the next two weeks? | O YES O NO |
| 6. Have you received any vaccinations in the last month? | O YES O NO |
| 7. Do you have any of the following illnesses or conditions? Chronic lung disease (including asthma), heart disease, diabetes, brain, spinal cord or muscle illness that causes swallowing or lung problems, problems with the immune system caused by medications and/or HIV, kidney disease, liver disease, blood disorders | O YES O NO |

**Please identify which H1N1 priority group you are in (please choose only one):**

O Pregnant women
O Household contacts/caretakers of children under 6 months
O Healthcare worker / EMS
O Children ages 6 months to 24 years
O Non-elderly adults (25 – 64 yrs) with underlying risk conditions
O None of the above

**CONSENT FOR VACCINATION:**

I have read or had explained to me the Vaccine Information Statement (10/02/2009) for the 2009 H1N1 Influenza Vaccine and understand the risks and benefits of receiving the vaccine. I have had a chance to ask questions, which were answered to my satisfaction. I hereby release this provider, its employees and its volunteers from any liability for any results which may occur from the administration of this vaccine.

**Signature:** _____ **Date:** _____

**STOP - DO NOT WRITE BELOW THIS LINE**

| H1N1-2009 VIS | Manufacturer | Dosage | Site / Lot No. | Administered By: |
|---|---|---|---|---|
| 10/02/2009 | O SP O GSK O NOV O MI O CLS | O 0.20 mL O 0.50 mL | Site O RD O RT O LD O LT O Intranasal; Lot No. | Name: Title: |

**H1N1 PIN:** 0210

**Provider Name:** TRICOUNTY HEALT

**Provider Type:** ● Public O Private

**Date Administered:** MM / DD / YYYY

**Revised 10/16/2009**

**For Persons 18 years and Older**

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