



Town of Agawam
Health Department
 36 Main Street
 Agawam, MA 01001
 Tel: 786-0400 ext. 207 Fax: 786-9927

H1N1 Consent Form

Please bring completed form to Public H1N1 Clinic. In addition, please read the VIS Form (Vaccine Information Statement) prior to attending the clinic which is available on this site.

Name: _____ DOB: _____ Age: yr ___ mo ___ M / F
 Address: _____ Phone: _____
 School Name: _____ Grade: _____ Room: _____

**Children under 10 years of age will need 2 doses of vaccine, one month apart.
 Children and adults over 10 years of age will only need 1 dose of vaccine.**

SCREENING QUESTIONNAIRE

Please read and answer the following questions. Your answers will determine whether you will receive the H1N1 Injectable or H1N1 nasal spray. (Providing both formulations are available at the clinic).

1. Are you sick today? Yes _____ No _____
2. Do you or your child have a serious allergy to eggs? Yes ___ No ____
3. Do you or your child have a serious allergy to gentamicin, neomycin, polymyxin, gelatin or thimerosal? Yes ___ No ____
4. Have you or your child ever had a serious reaction to influenza vaccine in the past? Yes ___ No ____
5. Is your child younger than age 2 or are you older than age 49? Yes ___ No ____
6. Do you or your child have long-term health problems with heart disease, lung disease, kidney disease, neurologic or neuromuscular disease, metabolic disease (e.g. diabetes) or anemia or another blood disorder? Yes ___ No ____
7. Have you or your child had an episode of Wheezing or Asthma in the past 12 months? Yes ___ No ____
8. Are you or your child receiving aspirin therapy or aspirin containing therapy, long term treatment with high dose steroids or cancer treatment with radiation or drugs? Yes _____ No _____
9. Are you pregnant or plan to become pregnant in the next month? Yes ___ No ____
10. Have you or your child ever had Guillain-Barre' syndrome? Yes ___ No ____
11. Do you live or plan to visit a severely immune compromised person, (e.g. bone marrow transplant)? Yes ___ No ____
12. Have you or your child received any vaccinations in the last 4 weeks? Yes _____ No _____

Signature of Patient or Parent /Guardian _____ Signature of Screener _____

Immunization Consent Form

**I give consent for myself or my child _____ to receive the H1N1 Flu vaccine.
 I have received and read the Vaccine Information Statement (VIS) explaining the benefits and risks of receiving the H1N1 flu vaccine and I consent to have myself or my child immunized.**

X _____
 Signature of patient or parent / legal guardian

 Date

For Clinic Office Use Only

H1N1 Flu Vaccination – Immunization Documentation

Dose # 1	
Date: _____	Vaccine: <i>H1N1</i>
Site: LA RA IN	Route: IM Inh
Dose: 0.2ml .25ml .5ml	
Manufacturer: Sanofi	Novartis
Lot #: _____	Expiration: 4/20/10 4/2011 5/2011
Vis Given: _____	Date on VIS: <i>10/2/2009</i>
Signature of Immunizer: _____	