



**JEFFERSON COUNTY HEALTH DEPARTMENT
IMMUNIZATION CONSENT AND HISTORY**

PARENT/GUARDIAN FULL NAME _____

PATIENT'S LAST NAME		PATIENT'S FIRST NAME		MI	ID #	DATE OF BIRTH	AGE
STREET ADDRESS			CITY	STATE	ZIP CODE	PHONE #	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
RACE (select all that apply) <input type="checkbox"/> Amer Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American		<input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White		ETHNICITY <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non Hispanic or Latino		CLINIC NAME/ SCHOOL/GRADE	

I have been given a copy and have read, or had explained to me, the information in the "Vaccine Information Statement(s)," where applicable, for the vaccine(s) indicated below. I have had a chance to ask questions and had them answered to my satisfaction. I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine(s) currently due for which I have signed below be given to me or to the person named above for whom I am authorized pursuant to Section 431.058, RSMo to make this request.

I understand that children less than 10 years old will require two doses of vaccine separated by at least 21 days in order to immunize the child against influenza. By signing this immunization consent, I agree to have the person named above be vaccinated with the complete two dose series for influenza.

A. If you answer "NO" to all four of the following questions, the person being vaccinated can probably get the influenza vaccine. If you answer "YES" to one or more of the following four questions, the person being vaccinated may be able to get the 2009 H1N1 vaccine, but we need to discuss the options with you.

1. Does the person being vaccinated have a serious allergy to eggs?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the person being vaccinated have any other serious allergies? Please list: _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the person being vaccinated ever had a serious reaction to a previous dose of flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the person being vaccinated 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"/>

B. There are two kinds of 2009 H1N1 influenza vaccine. Your answers to the following questions will help us know which of the two kinds of vaccine is appropriate.

1. Has the person being vaccinated gotten vaccinated with any vaccine (not just flu) within the past 30 days? Vaccine: _____ Date given: month _____ day _____ year _____	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the person being vaccinated have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood?	<input type="checkbox"/>	<input type="checkbox"/>
3. Is the person being vaccinated on long-term aspirin or aspirin-containing therapy (for example, take aspirin every day)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Does the person being vaccinated have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Is the person being vaccinated pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does the person being vaccinated have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?	<input type="checkbox"/>	<input type="checkbox"/>

Patient or Parent/Guardian Consent	
Date: _____ Signature: _____	Patient Guardian

Vaccinator only (Check): 0.2ml intranasal 0.25ml thimerosal free 0.5ml thimerosal free 0.5ml preservative containing
This is dose number: 1 2

H1N1 Influenza:

M/D/Y Given	Injection site	Vaccine Manufacturer	Lot Number	Date VIS Given	Vaccinator Signature

Medicaid Number: _____ Medicaid Provider _____

Private Insurance Carrier _____ Group No. _____ Member No. _____