



Preble County General Health District

615 Hillcrest Drive

Eaton, Ohio 45320

Phone: 937-472-0087 Nursing Fax: 937-456-6350

INFORMATION REGARDING PERSON TO RECEIVE VACCINE (Please Print)

Last Name:	First:	Middle Initial:	Birth date:	Age:	Tel. Number
Street Address:		City	State:	County:	Zip:

Screening Questionnaire & Consent for H1N1 Influenza Vaccination
INJECTABLE VACCINE

The following questions will help us determine if there is any reason we would not give you or your child intranasal influenza vaccine (Flu Mist) today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	YES	NO	DON'T KNOW
1. Are you sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you allergic to eggs or have an allergy to any medicines or vaccines?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had a serious reaction to influenza vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had Guillain-Barre' syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Consent for Vaccination:

I have read or have had explained to me the 2009-2010 Vaccine Information Statement for the 2009 H1N1 vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of H1N1 vaccine and ask that the vaccine be given to me or the person named below for whom I am authorized to make this request.

I hereby acknowledge receipt of the Preble County General Health District's NOTICE OF PRIVACY PRACTICES. I also give permission to release my immunization record to the Ohio Department of Health via the Impact SIIS system.

I consent to receive the **H1N1 Vaccination**.

Signature _____ **Date** _____
 (Signature of person to receive vaccine/or legal guardian)

To be completed by Nurse:

Date Administered	Vaccine Manufacturer	Lot Number	Site of Injection	Administrator and Title
	CSL		LD RD	
	Novartis			
	Sanofi Pasteur		LT RT	