



Roxbury Township Health Department

2009 H1N1 Influenza Vaccine Consent Form

Section 1: Information about client to receive vaccine (Please Print)

Client's Name (Last)	(First)	(M.I.)	Date of Birth
			Month: Day: Year:
Mailing Address:		Age:	Gender:
			Male <input type="checkbox"/> Female <input type="checkbox"/>
City:	State:	Zip Code:	Home Phone #:
Parent/Guardian Name: <i>If applicable</i>		Relationship to Client (Circle):	Municipality (if different from mailing address):
		Self Mother Father Legal Guardian Foster Care	
		Aunt Uncle Grandmother Grandfather	

Section 2: Screening

A. If your child has already been vaccinated with 2009 H1N1 influenza vaccine, please provide the following information (for age 10 years and younger only):

Form: Nasal Spray Shot Date Received: Month _____ Day _____ Year _____

B. The following questions will help us to know if you can get the 2009 H1N1 influenza vaccine. Please mark YES or NO for each question.

	YES	NO
1. Does the person named above have a serious allergy to eggs or to a component of the vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
2. Is the person to be vaccinated sick today or has he/she been sick in the past 24 hours?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the person named above ever had a serious reaction to a previous dose of flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the person named above ever had Guillain-Barre Syndrome (a type of severe muscle weakness) within 6 weeks after receiving a flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>

Section 3: Consent for Vaccination

I have read or had explained to me the 2009-2010 Vaccine Information Statement for 2009 H1N1 influenza vaccine and understand the risks and benefits.

I GIVE CONSENT to the STATE/LOCAL health department and its 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 also consent to having this data recorded in the NJIIS (New Jersey Immunization Information System).

Signature (self if 18 years or older, parent/legal guardian if child is under 18 years of age)



_____ Date: Month Day 2009

Section 4: Vaccination Record *For Administrative Use Only*

Vaccine	Date Given	Route IM	Staff Initial	Dose	Vaccine Manufacturer	Lot Number
2009 H1N1		R <input type="checkbox"/> L <input type="checkbox"/>		1 st <input type="checkbox"/>		
		Arm <input type="checkbox"/> Leg <input type="checkbox"/>		2 nd <input type="checkbox"/>		