

SUNY Potsdam
Student Health Services
2009 H1N1 Influenza Vaccine Consent

Please complete areas in black

Name (please print)	Date of Birth	Age
Address	City	State Zip
Parent/Guardian (please print)	Sex	Patient Phone
	M F	

HAVE YOU EVER HAD ANY OF THE FOLLOWING?	
Allergy to eggs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy to latex?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy to Thimerosal or Mercury?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Previous reaction to flu vaccine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Guillain-Barre' Syndrome?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Illness in the last 7 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did this illness include a fever?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you take any medication? (If yes, please list on back)	<input type="checkbox"/> Yes <input type="checkbox"/> No
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DO YOU HAVE ANY OF THE FOLLOWING?	
Any blood disorder <u>including</u> anemia?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lung disease, <u>including</u> asthma?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney or liver disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Severely weakened immune system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Neurological problem that could impair swallowing or breathing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart disease (except hypertension)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Recent vaccines?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you take daily aspirin therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No

INFLUENZA CONSENT	
I have answered the questions above accurately, and I have read, or had explained to me, the Vaccine Information Sheet (VIS) about 2009 H1N1 influenza vaccination. I have had a chance to ask questions which were answered to my satisfaction and I understand the benefits and risks of the vaccination as described. I request that 2009 H1N1 influenza vaccination be given to me, or the person named above for whom I am authorized to make this request. Furthermore, I agree to wait in the waiting area for 15 minutes after I receive the vaccination.	
_____	_____
Signature of Recipient (or Parent/Guardian)	Date

VIS Date: 10-2-09

Please administer this H1N1 vaccine _____
Signature of Provider

Time forms turned in: _____ Time left clinic: _____