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Freeholder Director

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Freeholder Liaison



**Gloucester County**  
Department of Health  
and Senior Services

**Division of Health**

**2009 H1N1 Injectable Influenza Vaccine Consent Form**

**SECTION 1: INFORMATION ABOUT PERSON RECEIVING VACCINE (PLEASE PRINT)**

NAME (Last)	(First)	(M.I.)	DATE OF BIRTH ____ / ____ / ____ month / day / year
MAILING ADDRESS			GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
CITY	STATE	ZIP	

**SECTION 2: SCREENING FOR INJECTABLE VACCINE ELIGIBILITY ONLY**

The following questions will help us to know if the person named above can get the 2009 H1N1 influenza vaccine. Please mark YES or NO for each question. Individuals with vaccine or egg allergies may need to consult their physician before getting the vaccine.

	YES	NO
1. Has the person named above <i>EVER</i> had any type of flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
2. Is the person to be vaccinated sick today with a fever over 100°?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does the person named above have a serious allergy to eggs, vaccine components or the flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the person named above 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"/>

**SECTION 3: CONSENT FOR VACCINATION**

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

**I GIVE CONSENT** to the Gloucester County Department of Health and Senior Services and associated 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 understand that the information contained within this record is being maintained to monitor immunization needs in order to prevent disease. This information is confidential and will only be shared with organizations or persons who are authorized by law to receive it. This includes the New Jersey Department of Health and Senior Services, a health care provider or health care organization providing treatment or health care services on behalf of an individual or on behalf of a child, a child's school or childcare and anyone else authorized under law to receive it. *(If this consent form is not signed & dated, then the person named above will not be vaccinated)*

Signature (if under 18, then legal guardian signature): \_\_\_\_\_

Print Name (if signed by a legal guardian) \_\_\_\_\_ Date: \_\_\_\_\_

<i>FOR ADMINISTRATIVE USE ONLY</i>				
Vaccine	Date Dose Administered	Route/Site	Staff Initial	Vaccine Information
2009 H1N1		IM <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Arm <input type="checkbox"/> Leg		<input type="checkbox"/> Novartis 102138P1A Exp 3/31/2010 <input type="checkbox"/> Sanofi UP031AA Exp 4/24/2011 <input type="checkbox"/> Sanofi UP039AA Exp 4/27/2011