

**Jackson County Health Department
2009-2010 H₁N₁ Influenza Vaccine Consent Form**

PLEASE PRINT

Last Name: _____ First Name: _____ Middle Name: _____
 Age: _____ Date of Birth: _____ Gender: (Male/Female)
 Address: _____ City: _____ Zip Code: _____
 Telephone Number: _____

Have you ever had:	Yes	No
Serious reaction to seasonal influenza vaccine?		
Serious allergic reaction to eggs?		
Guillain-Barre Syndrome?		
If you answered yes to any of these questions, you SHOULD NOT get either vaccine.		

Screening for Intra-Nasal Mist	Yes	No
Are you over the age of 49?		
Have you taken a MMR, Chickenpox or Season Flu Mist in last 4 weeks?	If yes, when _____	
Do you have a history of Asthma?		
Are you in contact with someone who has a severely weakened immune system?		
Are you pregnant?		
Do you have muscle/nerve disorders that can lead to breathing or swallowing problems?		
Do you have heart, lung, kidney, liver, diabetes, anemia or blood disorder?		
Are you on long-term aspirin therapy?		
If you answered yes to any of these questions, you DO NOT qualify for the Intra-Nasal Mist.		

I have read the vaccine information statements for the Intra-Nasal H₁N₁ Influenza Vaccine and/or the Injectable Influenza Vaccine (VIS dates 10/2/09). I understand that, depending on the answer to the questions above, I will receive either the injectable or the intra-nasal flu vaccine. I understand the benefits and risks of the vaccine and request that this be given to me.

Signature

Date