

**Town of Ipswich Board of Health
2009 H1N1 Flu Vaccine Consent Form – Injectable Flu Shot Only**

Section 1: Information about Person to Receive Vaccine (please print)

NAME (Last)	(First)	(M.I.)
DATE OF BIRTH / /	AGE	GENDER M / F
ADDRESS		
CITY	STATE	ZIP
DAYTIME PHONE NUMBER:		

Section 2: Screening for Vaccine Eligibility

If you have already been vaccinated with 2009 H1N1 flu vaccine, please tell us the number of doses and dates of vaccination.

- | | | | | |
|---------------------------------|-------------------------------------|-----------------------|-------------|------|
| <input type="checkbox"/> Dose 1 | Date received: month__day__year____ | Form (please circle): | nasal spray | shot |
| <input type="checkbox"/> Dose 2 | Date received: month__day__year____ | Form (please circle): | nasal spray | shot |

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

If you answer “YES” to one or more of the four questions, you will not be able to receive the 2009 H1N1 flu vaccine. If you answer “NO” to the following questions you will receive the vaccine unless a concern arises following additional screening. If you are not sure of the answers to these questions, please check with your healthcare provider.

	YES	NO
1. Do you have a serious allergy to eggs?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have a serious allergy to gentamicin, neomycin, polymixin or gelatin (components of the vaccine)?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had a serious reaction to a previous dose of flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you 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"/>

List other serious allergies: _____

Section 3: Consent

CONSENT FOR VACCINATION:	
I have read or had explained to me the 2009-2010 Vaccine Information Statement for the H1N1 flu vaccine and understand the risks and benefits.	
I GIVE CONSENT to get vaccinated with this vaccine. Signature _____ Date: month ____ day ____ year ____	I DO NOT GIVE CONSENT to get vaccinated with this vaccine. Signature _____ Date: month ____ day ____ year ____



PLEASE BE SURE TO READ AND SIGN THE REVERSE SIDE OF THIS FORM

Section 4: Permission to Share Information:

I, _____, give permission to the individual and/or entity that
(Print your name)
administered the 2009 H1N1 vaccine to me to share copies of the 2009 H1N1 vaccination record with my health care provider named below, as well as with the Massachusetts Department of Public Health and the local board of health in my community. I also give permission for each of these entities to share the 2009 H1N1 vaccination record with each other.

My health care provider:

Name: _____

Address: _____

- This health information is disclosed at my request and to ensure that I am appropriately vaccinated.
- This permission expires one year from the signature date.
- If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information received may no longer be protected by federal privacy regulations. State privacy regulations cover information received by the MA Department of Public Health and local boards of health.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain the vaccination.
- I understand that I may inspect or copy the protected health information to be disclosed under this permission to share.
- Finally, I understand that I may withdraw this permission in writing at any time by sending written notification to:

Colleen Fermon, Health Director, Ipswich Health Office, 25 Green Street, Ipswich MA 01938

However, if I withdraw permission at a later date, any vaccine record already shared will not be covered by the withdrawal.

Print name

Signature

Address

Date