2009-2010 H1N1 INFLUENZA VACCINATION CONSENT AND ADMINISTRATION RECORD

MARYLAND

Patient - Please Complete Sections 1 Through 8, Sign and Date
(Print clearly in capital letters using blue or black ink and neatly color in circles)

STATE OF MARYLAND DHMH

1. **LAST Name:**

First Name: **Middle Initial:**

Address:

City: **State:** **Zip:**

Date of Birth: MM / DD / YYYY **Gender:** ○ M ○ F **County Code** (*See Back*)**:**

Phone Number: - -

2. **Ethnicity: Hispanic or Latino:** ○ Yes ○ No

3. **Race** (*Color in all that apply*)**:**
○ American Indian/Alaskan Native ○ Asian ○ Black/African-American
○ Native Hawaiian/Pacific Islander ○ White ○ Unknown
○ Other (Specify) _____

4. **Which dose of the H1N1 Vaccine are you receiving?** ○ Dose 1 ○ Dose 2 ○ Don't know

5. **Are you pregnant?** ○ Yes ○ No ○ Unknown

6. **Do you live with or care for children younger than 6 months old?** ○ Yes ○ No

7. **Are you a health care or emergency medical service worker with direct patient contact?** ○ Yes ○ No

8. **Do you have an underlying risk factor such as asthma or other chronic health condition or a compromised immune system?** ○ Yes ○ No

CONSENT AND REQUEST TO RECEIVE H1N1 VACCINATION. I have read the information above and confirm that it is correct. I have been given a copy and have read, or I have had explained to me, the information in the "Vaccine Information Sheet for the H1N1 vaccine. I have had the chance to ask questions and they were answered to my approval. I understand the benefits and risks of the H1N1 vaccine and I have given my permission to have this vaccine given to me or the person for whom I have the power to make this request. I have been given, or have been offered, a copy of the Notice of Privacy Practices.

Signature of the person receiving and/or consenting to the vaccination:

_____ _____ Date: _____

Relation to person receiving the vaccination

For Clinic Use Only

Client Screened for Contraindications: Screener's Initials _____

Client given VIS on _____ and understands VIS dated _____

Manufacturer: ○ CSL ○ Medimmune ○ Sanofi Pasteur ○ GSK ○ Novartis Lot #:

Dosage (If applicable): ○ 0.25mL (6-35 months) ○ 0.50mL (3 years and older) ○ Other _____

Route of Administration: ○ Intranasal IM Injection: ○ LA ○ RA ○ LL ○ RL ○ Other _____

Clinic Site:

Place Stamp Here

Provider #:

Date: MM / DD / YYYY

Signature of Vaccinator: _____