Health Department Use ONLY
CI# _____
Encounter # _____

VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment

SCHOOL EMPLOYEE 2009 H1N1 INFLUENZA VACCINATION CONSENT FORM

SECTION A: CLIENT INFORMATION

Name (Last, First, Middle) :			
Date of Birth: / /	Age:	Gender: ❑ M ❑ F	
School:	Position:		

SECTION B: CONTACT INFORMATION

Name (Last, First, Middle) :			
Address:		City/State:	Zip:
Phone:	Home:	Work:	Cell:

SECTION C: SCREENING FOR VACCINE ELIGIBILITY

If you have already been vaccinated with **2009 H1N1 influenza vaccine**, please tell us the dates of vaccination.

Date received: month_____day_____year_____ Form (please circle): nasal spray shot

SECTION D: CLIENT HEALTH HISTORY

The following questions will help us know if you can get the 2009 H1N1 influenza vaccine. Please mark either **Yes** or **No** for each question. Do not leave any question unanswered.

If you answer "NO" to all of the following questions, you can probably get the influenza vaccine. If you answer "YES" to one or more of the following questions, you <u>may</u> be able to get the H1N1 vaccine, but we will contact you to discuss your options.

	Yes	No
1. Have you ever had a serious allergic reaction to eggs or the antibiotic gentamicin?	❑	❑
2. Have you ever had a serious reaction to a previous dose of seasonal flu vaccine?	❑	❑
3. Have you ever had Guillain-Barré syndrome (GBS), (i.e. paralysis) within 6 weeks after receiving a flu vaccine?	❑	❑
4. Do you have any other serious allergies that you know of? Please list: _____ _____	❑	❑
5. Are you taking any prescription medication to prevent or treat flu?	❑	❑
6. Do you have asthma, wheezing, difficulty breathing, or lung disease?	❑	❑
7. Do you have a long-term health problem such as heart disease, kidney disease, metabolic disease (e.g., **diabetes**), or blood disorders (e.g., **anemia**)?	❑	❑
8. Do you have a weakened immune system caused by cancer, cancer treatment (e.g., x-rays or drugs), HIV/AIDS, other disorders, or medicine (e.g. steroids)?	❑	❑
9. Do you live with or have a close contact with anyone with a severely weakened immune system requiring care in a protected environment (such as a hospitalized family member receiving chemotherapy)?	❑	❑
10. Are you 18 years old or younger AND taking aspirin or other aspirin-containing therapy?	❑	❑
11. Have you received an MMR (measles/mumps/rubella), varicella (chickenpox), or the live intranasal seasonal influenza vaccine (LAIV) within the past 4 weeks?	❑	❑
12. Do you have a muscle or nerve disorder (such as cerebral palsy) that can lead to breathing or swallowing problems?	❑	❑
13. Are you pregnant or nursing?	❑	❑

SECTION E: CONSENT FOR VACCINATION

I have read the **2009 H1N1 Influenza CDC Vaccination Information Statements (VIS)** for the H1N1 influenza shot and for the nasal spray. I understand the risks and benefits, and give consent to the Health Department and its authorized staff to vaccinate me with this vaccine.

Signature of Client: _____ _____ **Date:** _____ / _____ /_____

Over

SECTION F: OFFICE OF PRIVACY AND SECURITY
Authorization for Disclosure of Protected Health Information

As the person signing this authorization, I understand that I am giving permission to the Virginia Department of Health (VDH) to disclose personal health information to the person(s) or organization(s) indicated below.

- I understand the provision of treatment cannot be conditioned on my signing of this Authorization for Disclosure Section.
- Any health information re-disclosed by you will no longer be protected by this authorization.
- The original or a copy of the authorization shall be included in my medical record.
- I have the right to revoke this authorization at any time, except to the extent that action has been taken prior to my request to withhold my medical record. The request must be in writing and will be effective upon delivery to the provider in possession of my medical records.
- I authorize VDH to disclose my health information to my primary care physician.
- I understand that this record will be retained for ten years after the last visit or for five years after age 18, whichever comes later.
- I understand this document will be given to and retained by the public health department and will not be maintained by the school.

SECTION G: NOTICE OF DEEMED CONSENT
(Required by §32.1-45.1 of the Code of Virginia (1950), as amended)

If the health care provider or the person acting under the health care provider's direction and control is directly exposed to my blood in a way that may transmit disease, I understand that the law requires me to give a venous blood sample for further tests. I understand that the tests to be performed are for human immunodeficiency virus (HIV), hepatitis and/or other infectious diseases and that a physician or health care provider will inform me and the exposed provider of the results of the test.

I understand that the Virginia Department of Health will not release private medical records unless authorized above or to continue care.

_____ _____ _____
Please Print Your Name Signature Date

HEALTH DEPARTMENT USE ONLY

Date Dose Administered	Item code	Dose Number (1st or 2nd)	Vaccine Manufacturer	Lot Number	Vaccine Administration Site	Provider #
	H1N1-MIST				NAS	
	H1N1-PED-PC				RA LA	
	H1N1-PED-PF				RA LA	
	H1N1-3PLUS-PC				RA LA	
	H1N1-3PLUS-PF				RA LA	

Comments: (Enter reason if vaccine not administered)

Provider Signature: _____ Date: _____/ _____/ _____

10/07/09