

H1N1 Pandemic Influenza Vaccine Consent and Record of Immunization



MCP _____
 Last Name _____ First Name _____
 DOB _____
 Address _____ Postal Code _____
 Telephone (h) _____ (w) _____ (c) _____

Screening Questions	Check the Correct Box		
	Yes	No	Unsure
Are you sick or do you have a fever today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any medical problems (e.g. previous GBS, heart disease)? If yes, please describe _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant, if yes how many months _____?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a history of allergies? (<i>medications, vaccine, food e.g. eggs</i>) If yes, please list _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had the flu shot before?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a reaction to a flu shot? (<i>red eyes ,hives, rash, or difficulty breathing</i>) If yes, please describe _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Adverse Reactions

- Common side effects include: soreness and redness at the injection site that may last up to two (2) days.
- Less often side effects include: headache, muscular aches/pains, red eyes, cough, and sore throat.
- Allergic reactions such as breathing problems and hives are very rare and may occur with extreme sensitivity to certain components of the vaccine.

Consent
 I understand the information regarding the risks and benefits of the pandemic influenza vaccine provided by the Health Care Provider.

 I understand that my or my dependant's vaccination information will be entered in the NL immunization database

 I **CONSENT** for me or my dependant to have the pandemic influenza vaccine, two (2) doses for children under age 10 years.

 Signature _____
 Relationship to child/person _____
 Date _____

Refusal
 I understand the information regarding the risks and benefits of the pandemic influenza vaccine provided by the Health Care Provider.

 I **REFUSE** for me or my dependant to have the pandemic influenza vaccine

 Signature _____
 Relationship to child/person _____
 Date _____

↓ Health Care Provider administering the vaccine to complete ↓

Consent: Contraindicated Refusal Consent on file

Target Groups: Tick all that apply

Chronic illness Resident in remote areas First responder
 Pregnant Household contact/care provider of infant < 6mos or immunocompromised Poultry or Swine Worker
 Health Care Worker* Aboriginal resident

*Employed by the Regional Health Authority administering this vaccine Yes No

Immunization Record

Date/Time	Vaccine	Antigen Lot #	Adjuvant Lot #	Box Lot #	Dose	Route	Site	Signature
						IM.		
						IM.		

yyyy/mm/dd