

DURHAM COUNTY HEALTH DEPARTMENT

H1N1 INFLUENZA VACCINATION CONSENT FORM

Patient's Last Name _____ First Name _____ Middle Initial _____

Mother's Maiden Name (Last, First) _____

Date of Birth _____ Age _____ Gender: Male Female Ethnicity: Hispanic Non Hispanic

Race White Black or African American American Indian Asian Other _____

Name of Parent or Guardian Responsible for Patient (Last, First) _____

Address _____ City _____ State _____ Zip _____

County of Residence _____ Telephone Number _____

PLEASE ANSWER ALL OF THE FOLLOWING:

- 1. Are you currently pregnant? Yes No
2. Do you have an allergy to eggs? Yes No
3. Do you have any acute/chronic medical conditions such as heart disease, diabetes, asthma, cancer or any condition that affects your immune system? Yes No
4. Have you ever had a reaction to a previous dose of influenza vaccine? Yes No
5. Are you in contact with a person with a severely weakened immune system requiring care in a protected environment? Yes No
6. Are you employed as a healthcare worker providing direct patient care? Yes No
7. Do you live in a home with any infants under 6 months of age? Yes No
8. Have you received a live virus vaccine within the past 30 days? Yes No

Eligibility: American Indian/Alaskan Native Medicaid Not Insured NC Health Choice Insured

STATEMENT OF PERMISSION AND ASSIGNMENT:

I am authorized by the parent, guardian, or person standing in loco parentis of the above-named child to obtain needed immunizations for the child. I/parental designee have received the "Vaccine Information Statements" (VIS) about the disease(s) and vaccine(s). I have had a chance to review the VIS(s) and to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccines(s) and request the vaccine(s) indicated on the back of this form to be given to me or the person named above for whom I am authorized to make this request.

ACKNOWLEDGEMENT AND CONSENT: By placing my initials in the space(s) provided, I voluntarily give my permission for the following:
Acknowledgement of Receipt of the Notice of Privacy Practices

I hereby acknowledge that I have been offered a copy of the "Notice of Privacy Practices" for Durham County Health Department (DCHD) and understand I may contact the Privacy Officer at 919 560-7600 if I have questions about the content of the notice.

Insurance/Payment Information

I hereby authorize and request that payment of Medicaid or Medicare benefits I am entitled to, be paid directly to Durham County Health Department for all services furnished to me by any of the providers employed or contracted with DCHD. I understand that payment for this service may be made in accordance with the provisions of Title XVIII of the Social Security Act (Medicare) and/or Title XIX of the Social Security Act (Medicaid). I hereby authorize the provider of service to release information necessary for the processing of any claim for payment made on my behalf, and I authorize payment to the provider for such claim.

SIGNATURE - Patient/Parent/Legal Guardian _____

Date _____

VACCINE ADMINISTRATION

Vaccines Administered (check vaccine option administered)	Administration Site Del = deltoid V = Vastus Lateralis	Manufacturer/Lot No.	Date of VIS
H1N1 Inactivated Influenza Vaccine	<u>0.5 ml IM</u> L del R del LV RV		10/2/2009
H1N1 Intranasal Influenza Vaccine	Bilateral Nares		10/2/2009
H1N1 Inactivated Influenza Vaccine	<u>0.25 ml IM</u> L MLT R MLT		10/2/2009
<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>I have asked about prior immunizations and reactions. According to informant, no reactions have occurred.</p> </div> <div style="width: 65%;"> <p>Provider's signature: _____ X_____Provider#_____DATE_____</p> </div> </div>			

Data Entry by _____ Date _____

