

APACHE COUNTY PUBLIC HEALTH SERVICES
CONSENT FOR H1N1 INFLUENZA IMMUNIZATION

Please Print

Last Name	First Name	Middle Name	Date of Birth	Gender M F
Mailing Address		City	State	Zip Code
Phone Number			email	
Parent/Guardian Name			Teacher / Grade	

Check ALL that apply:

- Has **no** health insurance
- Has **Kids Care**, (attach copy of card, or fill in below);
Program _____ **#** _____
- Has **AHCCCS**, (attach copy of card, or fill in below);
Program _____ **#** _____
- Has health insurance (attach copy of card, both sides, or fill in below);
Insurance Provider _____ **ID#** _____ **GRP#** _____
- Is a **Native American**

I understand that by signing this consent form I am authorizing the Apache County Health Nurse to administer the H1N1 Influenza vaccine to my child.

Signature of parent/guardian: _____ Date: _____

Please complete health screen on back

Do not write below this line

For Health Department only.						
Date	H1N1	TIV or FluMist	Manuf	Lot #	Route	Vaccine Administrator

Screening Questionnaire for H1N1 Influenza Vaccination

For adult patients as well as parents of children to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child influenza vaccine today. If you answer “yes” to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1. Does the person to be vaccinated have allergies to medications, food, or any vaccine? Please list _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Has the person to be vaccinated had a serious reaction to flu vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> ^{1st} Flu
3. Does the person to be vaccinated have a long term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorders? If yes, please circle all that apply.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Does the person to be vaccinated have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as steroids, or cancer treatment with x-rays or drugs? If yes, please circle all that apply.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Is the person to be vaccinated receiving aspirin therapy or aspirin-containing therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Is the person to be vaccinated pregnant or could she become pregnant within the next month? L.M.P. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Has the person to be vaccinated ever had Guillain-Barré syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in a protective environment (such as in a hospital room with reverse air flow)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Has the person to be vaccinated received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Has the person to be vaccinated received vaccinations in the past 4 weeks? Please list _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Completed by: _____ Date _____

Reviewed by: _____ Date _____