

# H1N1 INFLUENZA VACCINE/NASAL SPRAY CONSENT FORM

## Statement of Understanding, Permission, and Agreement

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Age \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ Race \_\_\_\_\_ Sex: Male \_\_\_ Female \_\_\_

Address \_\_\_\_\_ Telephone # \_\_\_\_\_

Medicare Number \_\_\_\_\_

(Copy Front & Back of Card of Insurance Card)

Insurance Name: \_\_\_\_\_

Policy # \_\_\_\_\_

Address: \_\_\_\_\_

Medicaid Number \_\_\_\_\_

**STATEMENT OF UNDERSTANDING:** I have read and I understand the information provided to me about receiving vaccine for H1N1 Influenza or H1N1 Nasal Spray, and I have had the opportunity to ask questions. I understand that being allergic to eggs may be a reason for not receiving the vaccine. I affirm to the best of my knowledge that the following questions have been answered truthfully:

- |   | <u>Circle Yes or No</u> |    |
|---|-------------------------|----|
|   | Yes                     | No |
| 1. Are you allergic to eggs?                                      |                         |    |
| 2. Have you had a serious allergic reaction to influenza vaccine? |                         |    |
| 3. Do you have history of Guillain-Barre' Syndrome?               |                         |    |
| 4. Do you have a fever with a temperature above 100?              |                         |    |
| 5. Do you have asthma?  |                         |    |

Health Care Worker     2 yr.-24 yr.     25-64 with Medical Reason     Pregnant     < 6mos. Caregiver

**STATEMENT OF PERMISSION AND ASSIGNMENT:** I voluntarily give my permission to receive the H1N1 vaccine or nasal spray vaccine. 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); and/or private insurance or other third-party payor. 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

\_\_\_\_\_  
Date

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**For Provider Use Only:**

H1N1 Vaccine Mfgr./Lot# \_\_\_\_\_ Exp. \_\_\_\_\_

Injection Site: \_\_\_\_\_ Right \_\_\_\_\_ Left Deltoid

H1N1 Nasal Spray Vaccine Mfgr. \_\_\_\_\_ Exp. \_\_\_\_\_

Administered by: \_\_\_\_\_

Administered by: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_