



Branch: - Clinic:

# H1N1 IMMUNIZATION CONSENT FORM

First Name:  Middle Initial:

Last Name:

Address:

City:  State:  Zip:

County:

Phone: -- Birthdate:         Age:  Sex: (M/F)

Mother's Maiden Name:  Dose 1:  Dose 2:

Adults and Children Ages 10 and older only require 1 dose.

## PAYMENT INFORMATION

90663 Flu Injection 90470/G9141 Dx V04.81 \$   Coupon Coupon No.  AMOUNT PAID \$

MEDICARE ID NUMBER: (INCLUDING ALPHA)

Insurance Name:  Insurance ID No.:

### **Injectable Precautions and Contraindications: Please check YES or NO for each question.**

- |   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| 1. Do you have sensitivity to latex?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you allergic to chicken eggs and/or egg products?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you allergic to Thimerosal (used as a preservative in vaccines)?                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you exhibiting symptoms other than mild coughing, runny nose and/or diarrhea?                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have a history of Guillain-Barré Syndrome?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever had a serious reaction after receiving the influenza vaccine?                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are you pregnant or suspect you are pregnant? If so, please speak with the nurse prior to vaccination. | <input type="checkbox"/> | <input type="checkbox"/> |

CONTACT YOUR PHYSICIAN AND/OR HEALTH CARE PROVIDER BEFORE RECEIVING THIS VACCINE IF YOU CHECKED YES ON ANY OF THE ABOVE QUESTIONS.

### **Nasal Precautions and Contraindications: Please check YES or NO for each question.**

- |   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| 1. Are you 50 years of age or older?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you allergic to eggs, egg proteins, gentamicin, gelatin, arginine, and/or MSG?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you have a weakened immune system?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had a life threatening reaction to a previous influenza vaccination?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have asthma or active wheezing?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Did you have a history of Guillain-Barré Syndrome or active neurological disorder?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have kidney, liver, heart, lung and/or metabolic (diabetes) disease?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Are you pregnant or suspect you are pregnant?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you have anemia or any other blood disorder?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you received any live vaccines within the last month or do you plan to receive any within the next month?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Is your child or adolescent (2-17 years of age) receiving aspirin therapy or aspirin-containing therapy (because of the association of Reye's Syndrome with aspirin and wild type influenza infection)? | <input type="checkbox"/> | <input type="checkbox"/> |

If yes to any of the above, you must see your private physician to determine the necessity of receiving FluMist.

Manufacturer:  CSL  Medimmune  Sanofi Pasteur  GSK  Novartis LOT #:

Dosage: (if applicable):  0.25mL (6-35 months)  0.50mL (3 years and older) Route of Administration:  Intranasal Injection: Deltoid:  left  right Thigh:  left  right

## H1N1 VACCINE ADVERSE REACTIONS

Because influenza vaccine contains only non-infectious purified viral proteins, it cannot cause influenza. An occasional case of respiratory disease following immunization represents coincidental illnesses unrelated to influenza immunization. H1N1 nasal vaccine may cause mild symptoms which include: runny nose, nasal congestion or cough, headache and muscle aches, fever, wheezing, abdominal pain or occasional vomiting or diarrhea, sore throat, chills, tiredness/weakness.

**Local Symptoms:** Slight soreness, redness, or swelling at the site of injection may occur in some recipients.

**Systemic Symptoms:** Fever, malaise, myalgia, and other systemic symptoms occur infrequently and most often affect persons who have had no exposure to the influenza virus antigens in the vaccine (e.g., young children). If these problems occur, they usually begin soon after the shot and last 1 to 2 days. Immediate, presumable allergic reactions such as hives, angioedema, allergic asthma, or systemic anaphylaxis occur rarely after influenza immunization. These reactions probably result from hypersensitivity reactions in people with severe egg allergy and such people should not be given influenza vaccine. This includes people who develop hives, have swelling of the lips or tongue, or experience acute respiratory distress or collapse after eating eggs. People with documented immunoglobulin E (IgE)- mediated hypersensitivity to eggs, including those who have experienced occupational asthma or other allergic responses from occupational exposure to egg protein, may also be at increased risk of reactions from H1N1 vaccine.

Unlike the 1976-1977 swine influenza vaccine, subsequent non-H1N1 vaccine prepared from other virus strains has not been clearly associated with an increased frequency of Guillain-Barré Syndrome (GBS). Even if GBS were a true side effect, the very low estimated risk of GBS is less than that of severe influenza, which could be prevented by vaccination. Other neurological disorders, including encephalopathies, have been temporarily associated with influenza immunizations, but cause and effect has not been clearly established.

THE VACCINE SHOULD NOT BE ADMINISTERED TO PEOPLE WITH ACUTE FEBRILE ILLNESSES UNTIL THEIR TEMPORARY SYMPTOMS HAVE ABATED. HOWEVER, MINOR ILLNESSES WITH OR WITHOUT FEVER SHOULD NOT CONTRAINDICATE THE USE OF INFLUENZA VACCINE, PARTICULARLY AMONG CHILDREN WITH A MILD UPPER RESPIRATORY TRACT INFECTION OR ALLERGIC RHINITIS.

**CONTRAINDICATIONS: INFLUENZA VIRUS IS PROPAGATED IN EGGS FOR THE PREPARATION OF H1N1 VIRUS VACCINE; THUS, THIS VACCINE SHOULD NOT BE ADMINISTERED TO ANYONE WITH A HISTORY OF HYPERSENSITIVITY TO ANY COMPONENT OF THE VACCINE INCLUDING THIMEROSAL.**

## CONSENT FOR SERVICES, MEDICAL RECORDS and HIPAA PRIVACY INFORMATION

I have read the adverse reactions associated with the H1N1 vaccine. A copy of the vaccine manufacturer's drug information sheet is available on request. Furthermore, I have also had an opportunity to ask questions about this immunization. I believe the benefits outweigh the risks and I voluntarily assume full responsibility for any reactions that may result. My medical record may be shared with my physician/insurance. I am requesting that the immunization be given to me or the person named below for whom I am the legal guardian. I, for myself, my heirs, executors, personal representatives and assigns, hereby release Maxim, any retail site, grocery store, pharmacy, corporation, physician and/or medical director and their respective affiliates, subsidiaries, divisions, directors, contractors, agents and employees, from any and all claims arising out of, in connection with or in any way related to my receipt of this or this immunization. Maxim and the other aforementioned parties shall not at any time or to any extent whatsoever be liable, responsible, or in any way accountable for any loss, injury, death or damage suffered or sustained by any person at any time in connection with or as a result of this vaccine program or the administration of the vaccine described above.

Maxim will use and disclose your personal and health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed **NOTICE OF PRIVACY AND CONFIDENTIALITY PRACTICES** to help you better understand our policies in regards to your personal health information. I acknowledge that I have received a copy of the Notice of Privacy and Confidentiality Practices. I agree to remain in the general area for at least 15 minutes after receiving the vaccine.

Corporate Address: 7227 Lee DeForest Drive, Columbia, MD 21046, Phone No.: 866-211-0001 Tax ID No.: 52-1968516

I acknowledge that I have received the appropriate and current Vaccine Information Statement (VIS) issued by the U.S. Centers for Disease Control and Prevention from the nurse named below at the time of receiving my immunization, and hereby consent to the administration of the influenza vaccine described herein.

X \_\_\_\_\_  
Signature/Legal Guardian

\_\_\_\_\_  
Date of Service

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Nurse's Signature

Please provide a copy of this form to your physician and/or health care provider for your permanent medical records.