

Client Name: _____
 (please print) *Last* *First* *Middle Initial*

Date of Birth: _____

If any of the following health screening questions are not clear, leave it blank and a healthcare worker will explain it to you.

Check each box YES or NO.	YES	NO
1. Is the client sick today?		
2. Does the client have a serious allergy to eggs?		
3. Does the client have any other serious allergies to medications, food, latex, or any vaccines?		
4. Has the client ever had a serious reaction to a previous dose of flu vaccine?		
5. Has the client ever had Gullian-Barré syndrome (type of temporary severe muscle weakness) within 6 weeks of receiving flu vaccine?		
6. In the past 4 weeks has the client received any vaccinations?		
7. Does client have any of the following: recurrent wheezing, asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidney, liver, nerves, or blood?		
8. Is client on long-term aspirin or aspirin-containing therapy (example: daily dose of aspirin)?		
9. Does the client have a weakened immune system (examples: from cancer, leukemia, AIDS, or on medications for steroids or cancer)?		
10. Is female client pregnant?		
11. Does client have close contact with a person who needs care in a protected environment (example: someone who has recently had a bone marrow transplant)?		
12. Has client taken any influenza antiviral medications in the last week (example: Tamiflu, Relenza)?		

My signature below proves:

- I have read or had explained to me the Vaccine Information Statement for the seasonal / H1N1 Influenza vaccine and understand the risks and benefits.
- I consent to the administration of the seasonal / H1N1 vaccine to me or to the person for whom I am authorized to make this request.
- I verify that all of the above information I supplied is correct to the best of my knowledge.
- I have received the HIPAA privacy notice.

Signature of Client or Representative

Relationship to Client (if Representative)

Printed Name (if Representative)

_____/_____/_____
Date Signed

For Office Use Only (do not write below this line)

Healthcare provider comments:

Refusal to Consent to Vaccination

The healthcare worker has explained the purpose, risks and benefits, and possible consequences of not receiving seasonal / H1N1 vaccination. I understand that I may change my mind later, accept full responsibility for any consequences of not being vaccinated, and acknowledge that I have read and understand this statement.

Signature of Client or Representative

_____/_____/_____
Date Signed

Signature of Healthcare Worker

_____/_____/_____
Date Signed