

**2009 H1N1 FLU VACCINE CONSENT FORM & ADMINISTRATION RECORD**

I have received a copy of the Vaccine Information Sheet. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me or the person named below for whom I am authorized to make this request. I understand the DeKalb County Health Department staff will need to obtain a blood sample from the person receiving vaccine in the event a blood or body fluid exposure occurs to the vaccinator. I also received or was offered a copy of the Notice of Privacy Practices of the DeKalb County Health Department dated April 14, 2003.

<b>PLEASE COMPLETE THIS SECTION ABOUT THE PERSON TO RECEIVE VACCINE</b>				
<b>PLEASE <u>PRINT</u> LEGAL NAME</b>			<b>BIRTH DATE</b> MO / DAY / YR	<b>AGE</b>
LAST	FIRST	MIDDLE INITIAL		
<b>PHONE NUMBER</b>			<b>SEX</b> <input type="checkbox"/> M <input type="checkbox"/> F	
<b>STREET ADDRESS</b>	<b>CITY</b>	<b>STATE</b>	<b>ZIP CODE</b>	<b>COUNTY</b>
<b>MARK ALL THAT APPLY FOR THE PERSON RECEIVING THE VACCINE</b>			<b>CHECK AGE GROUP FOR PERSON RECEIVING VACCINE</b>	
<input type="checkbox"/> PREGNANT			<input type="checkbox"/> 24 MONTHS THROUGH 59 MONTHS	
<input type="checkbox"/> LIVE WITH OR CARE FOR INFANT LESS THAN 6 MONTHS OF AGE			<input type="checkbox"/> 5 YEARS THROUGH 18 YEARS	
<input type="checkbox"/> PERSON 6 MONTHS THROUGH 24 YEARS OF AGE			<input type="checkbox"/> 19 YEARS THROUGH 24 YEARS	
<input type="checkbox"/> PERSON 25 THROUGH 64 WITH CHRONIC MEDICAL CONDITION			<input type="checkbox"/> 25 THROUGH 49 YEARS	
<input type="checkbox"/> HEALTH CARE AND/OR EMERGENCY SERVICE PERSONNEL			<input type="checkbox"/> 50 THROUGH 64 YEARS	
<input type="checkbox"/> OTHER			<input type="checkbox"/> 65 YEARS AND OLDER	
<b>SIGNATURE OF PERSON TO RECEIVE VACCINE OR PERSON AUTHORIZED TO MAKE THE REQUEST (PARENT OR GUARDIAN):</b>				
<b>SIGNATURE:</b>			<b>DATE:</b>	

**FOR CLINIC/OFFICE USE ONLY**

CLINIC/OFFICE ADDRESS: DeKalb County Health Department, 2550 N. Annie Glidden Road, DeKalb, Illinois 60115

VACCINE MANUFACTURER: \_\_\_\_\_

VACCINE LOT NUMBER: \_\_\_\_\_

SITE OF INJECTION:       L OR R ARM IM      L OR R LEG IM      NASAL SPRAY

SIGNATURE OF VACCINE ADMINISTRATOR: \_\_\_\_\_

DATE VACCINE DOSE #1 ADMINISTERED: \_\_\_\_\_

DATE VACCINE DOSE #2 ADMINISTERED: \_\_\_\_\_