NEW MEXICO DEPARTMENT OF HEALTH

Public Health Division

H1N1 INFLUENZA (FLU) IMMUNIZATION
Consent Form

Last Name:____________________**First Name:**______________________**Middle Name:**________ **Gender: (M / F)**

Date Of Birth:__________ **Age:**____ **Mother's Maiden Name (children only)**:__________

Current Mailing Address:________________________________ **City:**_____________ **Zip:**___________ **Home Phone:**_________

INSURANCE INFORMATION

❑ **American Indian/Alaska Native** ❑ **Private Insurance Co.** ___________________________ ❑ **Medicaid/Salud**

❑ **No Health Insurance** ❑ **Underinsured** (Have commercial/private health insurance but coverage does not include vaccines, covers only selected vaccines, or insurance caps vaccine coverage at a certain amount.)

Race: (circle one) **AI/AN-**Am Indian/Alaska Native **A-**Asian **W-** White **B-**Black **O-**Other **Ethnicity: H –** Hispanic **NH** – Non-Hisp

1. Are you allergic to eggs?............ ☐ Yes ☐ No ☐ Don't Know
2. Have you ever had Guillain-Barré syndrome? .... ☐ Yes ☐ No ☐ Don't Know
3. Have you received a flu vaccination before? .... ☐ Yes ☐ No ☐ Don't Know
4. Have you had a serious reaction to flu vaccine in the past? .... ☐ Yes ☐ No ☐ Don't Know
5. Have you received any other vaccines in the past 4 weeks? .... ☐ Yes ☐ No ☐ Don't Know
   If yes, which one(s):__________________Date given:__________________
6. Are you allergic to gentamicin sulfate, gelatin or MSG?............ ☐ Yes ☐ No ☐ Don't Know
7. Do you have asthma or other lung disease? .... ☐ Yes ☐ No ☐ Don't Know
8. Do you have long-term health problems or heart disease? .... ☐ Yes ☐ No ☐ Don't Know
9. Do you have kidney disease or renal dysfunction? .... ☐ Yes ☐ No ☐ Don't Know
10. Do you have blood diseases (such as sickle cell anemia)? .... ☐ Yes ☐ No ☐ Don't Know
11. Do you have diabetes?............ ☐ Yes ☐ No ☐ Don't Know
12. Are you on long-term aspirin therapy? .... ☐ Yes ☐ No ☐ Don't Know
13. Do you or a family member 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?
    .... ☐ Yes ☐ No ☐ Don't Know
14. Are you pregnant or planning to become pregnant in the next month? .... ☐ Yes ☐ No ☐ Don't Know

Please list any allergies:____

IMPORTANT – for Children less than 9 years old: Has child received **two doses** of the flu vaccine in prior years? ❑ **Yes** ❑ **No**

I have been given a copy and have read, or have had explained to me, the information in the "Vaccine Information Statements" for influenza and the influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the influenza vaccine requested and ask that the influenza vaccine be given to me or the person above for whom I am authorized to make the request. If the person above for whom I am authorized to make the request is less than 9 years old and has not received two doses of the flu vaccine in prior years, I also request that a second dose of flu vaccine be given.

I agree to allow information on immunizations given to me or to the named person to be released to other medical care providers to avoid unnecessary vaccination or to ascertain immunization status.

Signature of parent/guardian or adult vaccine recipient ___________________________________**Date**___________________

FOR CLINIC USE (This section must be completed by the medical provider)		
Clinic ID# _____________ NMSIIS entry completed ❑	Date Vaccinated _________________ Provider Signature _________________ Vaccine used (check one): ❑ Flulaval ❑Fluarix ❑MedImmune FluMist® ❑SanofiPasteur Fluzone® Lot # ________________________ Site of Injection _________________	**2nd Dose if needed:** Date Vaccinated _________________ Provider Signature _________________ Vaccine used (check one): ❑ MedImmune FluMist® ❑SanofiPasteur Fluzone® Lot # ________________________ Site of Injection _________________