JACKSON COUNTY DEPARTMENT OF PUBLIC HEALTH – **H1N1 FluMist Consent 2009**

Please Print (Ages 2 Years through 49 years)

Last Name:________________________First Name:_____________________Middle Name:_____________Age:____

Address:_______________________________________City:_______________________ Zip Code:_______________

Date of Birth:__________Home Phone:______________Emergency Contact Number:_____________

Guardian, if under 18: Last Name:__________________ First Name:_____________ Relationship:_____________

If you or your child want an Influenza Vaccination, FILL OUT THE INFORMATION BELOW AND SIGN.		
Please CHECK YES or NO to ALL questions below for you or your child. The Nurse giving the vaccination will review the information on vaccination day.	**YES**	**NO**
Have you or your child received a "FLU" vaccination before (either Flu Shot or FluMist)?		
Have you or your child ever had a reaction to a flu shot? If yes, describe.		
Are you or your child allergic to vaccine components (i.e., eggs, gentamicin sulfate, MSG)?		
Have you or your child received a vaccine within the past 30 days? Vaccine name: Date:		
Do you or your child have asthma?		
Do you or your child have chronic heart diseases?		
Do you or your child have diabetes or other metabolic diseases/disorders?		
Do you or your child have kidney diseases?		
Do you or your child have blood diseases?		
Do you or your child have close contact with anyone who had bone marrow transplant in the last 6months?		
Have you or your child ever had Guillain-Barre syndrome?		
Are you or your child on long-term aspirin therapy?		
Do you or your child have a disease such as cancer, lupus, HIV/AIDS, or take a medication that lowers the body's resistance to infection?		
Are you or your child pregnant or nursing?		
List any allergies for you/child:		
Additional Notes:		

Request for Administration of Influenza Vaccine for the above named recipient: I am aware that the receiver of this vaccine is currently not pregnant nor will become pregnant within four weeks of receiving this vaccine. I have read information about the vaccine and special precautions on the Vaccine Information Sheet. I have had an opportunity to ask questions regarding the vaccine and understand the risks and benefits. I request and voluntarily consent that the vaccine be given to the person above of whom I am parent or legal guardian and acknowledge that no guarantees have been made concerning the vaccine's success. I hereby release Jackson County Government, their affiliates, employees, directors, and officers from any and all liability arising from any accident, act of omission or commission, which arises during vaccination. **This Consent Form is valid for administration of influenza vaccinations for six (6) months. It may be used to administer a second dose of influenza vaccine, if needed. I understand that I should report any changes of the above information prior to vaccination.**

____ _________________________

Parent /Guardian Signature **Date**

For Billing Purposes

I assign Medicaid/Medicare benefits to the Jackson County Department of Public Health. I understand that my signature will serve as legal "Signature on File" for the purpose of filing Medicaid/Medicare claim and payment of medical benefits to the Jackson County Department of Public Health for any services rendered. I authorize the release of any medical information needed to process claim.

--***FOR OFFICE USE BELOW***--

***Mfgr**______________**Lot#**__________**Exp**______**Site**___________**Administered By**_______________**Date**_______*