KFL&A PublicHealth

Influenza Consent
Arepanrix™ H1N1

Location:			
Name:		**Date of Birth:**	**Male** ☐ **or Female** ☐
Phone:	**Ontario Health Card #**	**Family Physician:**	
Are you:			
A pregnant woman ☐	A child 6 to 24 months of age ☐	A health care worker ☐	A higher health risk (asthma, diabetes, heart disease, cancer, etc.) ☐
An emergency services worker (e.g., Ambulance, Fire, Police) ☐	Over 65 years of age ☐		
Are you in regular contact with someone:			
In the higher health risk category ☐	Over 65 years of age ☐	Under 24 months ☐	Who is pregnant ☐

Have you had any influenza shot before?	No	☐	Yes	☐
Do you have allergies? (If yes, please discuss with the nurse)	No	☐	Yes	☐
Have you ever reacted to a vaccine?	No	☐	Yes	☐
Do you have a fever today?	No	☐	Yes	☐

Information on the influenza vaccine has been explained to me. I understand that the vaccine can help to protect me from the influenza virus. I have had the chance to ask questions which were answered to my satisfaction. I understand that the most common side effects to the influenza immunization are minor and that the risk of a vaccine causing serious harm is extremely small.

Parent/Guardian Consent:
I have read or had explained to me the information about the vaccine. I ask that the above named child be immunized against pandemic H1N1.

Parent/Guardian Signature: ____________________ Date: ____________________

Print Name: ____________________ (Parent or Guardian - please circle one)

For nurses use only:	
Vaccine 0.25 mL/0.5 mL administered intramuscularly.	
Lot#	
Right ☐	Left ☐
Deltoid/V. Lateralis	Date:
Signature of Nurse:	

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221 Portsmouth Ave., Kingston ON K7M 1V5
613-549-1232, ext. 1451

Name: ____________________

Immunization date: ____________________

Return date: Next Fall/One month ____________________

Vaccine administered: Arepanrix™ H1N1

KFL&A Public Health

FREE PANDEMIC H1N1 Immunization Clinics

Health History for Adjuvanted/Unadjuvanted H1N1 Influenza Vaccine

Do any of the following apply to you? Please review and inform Registration of your answers.

		YES	NO
1	Do you have a fever?	❑	❑
2	Have you received the 2009 Seasonal Flu vaccine?	❑	❑
3	Are you from a remote community (350km or more from access to any medical care)?	❑	❑
4	Are you a health care worker involved in the pandemic response or delivering essential health care services (includes full-time, part-time, students and volunteers)?	❑	❑

- a ❑ Acute Care
- b ❑ Chronic Care
- c ❑ Ambulatory/Community Care
- d ❑ Emergency Medical Services
- e ❑ Laboratory
- f ❑ Public Health
- g ❑ Pharmacies
- h ❑ Vaccine Manufacturers

		YES	NO
5	Are you a first responder with the police?	❑	❑
6	Are you a firefighter?	❑	❑
7	Are you a swine worker?	❑	❑
8	Are you a poultry worker?	❑	❑
9	Do you have a chronic condition?	❑	❑
a ❑	Do you have a cardiac or pulmonary disorder (including bronchopulmonary dysplasia, cystic fibrosis and asthma)?	❑	❑
b ❑	Do you have a diabetes mellitus or other metabolic diseases?	❑	❑
c ❑	Do you have cancer, immunodeficiency, or immunosuppression (due to underlying disease and/or therapy)?	❑	❑
d ❑	Do you have renal disease?	❑	❑
e ❑	Do you have anemia or hemoglobinopathy?	❑	❑
10	Do you have conditions that compromise the management of respiratory secretions and are associated with an increased risk of aspiration?	❑	❑
11	Are you a child or adolescent with conditions treated for long periods with acetylsalicylic acid?	❑	❑
12	Are you a pregnant woman?	❑	❑
13	Are you a household contact/caregiver to an infant less than 6 months old, or a household contact/caregiver to anyone who is immunocompromised?	❑	❑
14	Have you ever developed red eyes and/or respiratory problems such as cough, wheeze, difficulty breathing, hoarseness, sore throat and/or facial swelling within 24 hours after receiving a flu vaccine?	❑	❑
15	Have you ever had oculo-respiratory syndrome (ORS) requiring hospitalization?	❑	❑
16	Have you had Guillain-Barre syndrome (GBS) within 8 weeks of a past influenza vaccine?	❑	❑
17	Are you allergic to any of the following?		
a	○ Eggs or egg products	❑	❑
b	○ Chicken protein	❑	❑
c	○ Thimerosal	❑	❑
d	○ Polymyxin B sulfate	❑	❑
e	○ Neomycin	❑	❑

In providing the information in this form, I consent to the collection of personal health information for the purpose of providing vaccine, maintaining records, and surveillance and evaluation.

Signature:____________________ Date:____________

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December 2009