

Screening Questionnaire and Consent for H1N1 LAIV Influenza Vaccine

Information about the person to receive a vaccine (please print)		
WWU ID _____		
NAME: Last _____	First _____	M.I. _____
Birth Date _____	Age _____	Phone _____
Mailing Address _____		
City, State, Zip _____		

	Please answer the following questions by checking the boxes. If the question is not clear, ask the nurse to explain it.	Yes	No
1.	Is the person to be vaccinated sick today?		
2.	Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine? (Gelatin, Gentamicin sulfate, Arginine, Monosodium glutamate)		
3.	Has the person to be vaccinated ever had a serious reaction to intranasal influenza vaccine in the past?		
4.	Is the person to be vaccinated younger than 2 years or older than 49 years?		
5.	Does the person to be vaccinated have a long-term health problem with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., diabetes), or anemia or another blood disorder?		
6.	If the person to be vaccinated is a child age 2 though 4 years, in the past 12 months, has a healthcare provider ever told you that he had wheezing or asthma?		
7.	Does the person to be vaccinated have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as high dose steroids, or cancer treatment with radiation or drugs?		
8.	Is the child or teen to be vaccinated receiving aspirin or aspirin-containing therapy?		
9.	Is the person to be vaccinated pregnant or could become pregnant within the next month?		
10.	Has the person to be vaccinated ever had Guillain-Barre Syndrome?		
11.	Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (such as a bone marrow transplant recipient in a hospital room with reverse air flow)?		
12.	Has the person to be vaccinated ever fainted or become light-headed when getting a shot or when having blood drawn?		

“I have been given a copy and have read, or have had explained to me the information in the H1N1 Live, Attenuated Vaccine Information Statement. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine. I request that the H1N1 Live, attenuated intranasal vaccine (LAIV) be given to me or the person to be vaccinated.”

X _____
Signature of person authorizing vaccination

Date _____

Clinic purposes only:

Date Administered: _____ Route: Nasal Dosage: 0.2ml VIS Date: 10/02/09 Mfg. MedImmune Lot _____

Signature and Title of Vaccine Administrator