H1N1 INFLUENZA VACCINE ADMINISTRATION FORM

NAME (Last, First, M.I.) ______ DATE OF BIRTH ______ GENDER ______ BANNER ID# ______

STREET ADDRESS ______ APT # ______

CITY ______ STATE ______ COUNTY ______ ZIP CODE ______ TELEPHONE # ______

CONSENT FOR SERVICES

Request for administration of H1N1 flu shot for the above-named recipient: I have received a copy of the Vaccine Information Sheet (VIS) on the 2009 H1N1 influenza vaccination. I have read the precautions and contraindications associated with the H1N1 Influenza vaccine. I understand that a copy of the vaccine manufacturer's drug information sheet is available on request. Furthermore, I have also had an opportunity to ask questions about the vaccine. I believe the benefits outweigh the risks and I assume full responsibility for any reactions that may result. I am requesting that the vaccine be given to me or the person named below for whom I am the legal guardian. I for myself, my heirs, executors and assigns hereby release Rowan University, health providers, and employees from any claims arising out of, in connection with or in any way related to the receipt of this immunization. Rowan University and its employees shall not at any time or to any extent whatsoever be liable, responsible, or in any way accountable for any loss, injury, death or damage to be suffered or sustained by any person or at any time in connection with or as a result of this vaccine administration. I have never had a reaction to eggs or egg products. I am not allergic to neomycin or polymyxin. This vaccine contains trace thimerosal (≤ 1 microgram of mercury). I have never had a serious reaction to a flu vaccination and I do not have a history of Guillain-Barré syndrome. I understand that the information contained within this record is being maintained to monitor immunization needs in order to prevent disease. This information is confidential and will only be shared with organizations or persons who are authorized to receive it. This includes the New Jersey Department of Health and Senior Services or anyone else authorized under law to receive it. I understand that it is recommended that I wait 10 minutes before leaving if I have never had a flu shot. **For adults 25 years and older: I certify that I am a health care provider, pregnant, care for an infant under 6 months of age or have a chronic medical conditions to qualify to receive the vaccine** (This includes pulmonary disease (including asthma), cardiovascular disease (except hypertension), kidney disease, liver disease, cognitive disorders, neurologic/neuromuscular disorders, diseases of the blood, metabolic disorders (including diabetes mellitus) or immune compromised individuals (including immunosuppression caused by medications or by human immunodeficiency virus)).

SIGNATURE/LEGAL GUARDIAN ______ DATE ______

Please mark YES or NO for each Question

	Question	YES	NO
1.	Is the person to be vaccinated ill today?	☐	☐
2.	Does the person to be vaccinated have an allergy to eggs or a vaccine component?	☐	☐
3.	Has the person to be vaccinated had a serious reaction to an influenza vaccine in the past?	☐	☐
4.	Has the person to be vaccinated ever had Guillain-Barre's syndrome	☐	☐
5.	Is the person to be vaccinated allergic to dry natural latex rubber?	☐	☐

OFFICE USE ONLY – DO NOT WRITE

☐ Influenza A (H1N1) 2009 Monovalent Vaccine Novartis® H1N1 Influenza Virus Vaccine 90663/V04.81	☐ Single dose H1N1 immunization administration 90470

Influenza A (H1N1) 2009 Monovalent Vaccine Novartis ®	☐ Intramuscular Right Arm	☐ Intramuscular Left Arm	Lot # 10073803	Expiration Date: 01/2010

RN SIGNATURE (RN Administering Vaccine) ______ PRINT NAME ______ DATE ______