

VACCINATION CONSENT FORM

I have read or had explained to me the information in the "Vaccine Information Statement(s)" for the diseases(s) circled below. I have had a chance to ask questions and fully understand the benefits and risks of the vaccine(s) circled below. I request the vaccines I have circled to be given to me or the person named below.

H1N1 Vaccine #1 H1N1 Vaccine #2 H1N1 Flu mist#1 H1N1 Flu mist #2

Last Name _____ First Name _____ MI _____

Date of Birth _____ Age _____ Male () Female ()

Race: _____ Hispanic Origin _____

Guardian Name _____

Street Address _____

City _____ Zip Code _____ Email _____

Signature of parent of person to receive vaccine or person authorized to consent to the immunization.

Signature _____ Date _____

Office use only:

CLINIC LOCATION _____

Vaccine	Manufacturer and Lot #	Route and Site	Vaccine Information sheet date
H1N1 Flu mist #1		Nasal Spray	
H1N1 Flu mist #2		Nasal Spray	
H1N1 #1		Lt Arm/Thigh IM Rt Arm/Thigh IM	
H1N1 #2		Lt Arm/Thigh IM Rt Arm/Thigh IM	

Signature and Title of Vaccine Administrator and Date Vaccinated and VIS provided

Signature _____ Date _____