H1N1 Clinic - Consent for Immunization

Last/Family Name		First Name	
☐ Male ☐ Female	Date of Birth: year / month / day	Ontario Health Card Number	
Address		City	Postal Code
Home Phone ( )		Work Phone ( )	

Screening Questions	No	Yes	If "Yes", please describe
Have you received the 2009 Seasonal Flu vaccine?			
Are you from a remote community (350 km or more from access to any medical care)?			
Are you a health care worker involved in the pandemic response or delivering essential health care services (includes full-time, part-time, students and volunteer)?			
If yes to above, please check which field: ❑ Acute Care ❑ Ambulatory/Community Care ❑ Laboratory ❑ Pharmacies ❑ Chronic Care ❑ Emergency Medical Services ❑ Public Health ❑ Vaccine manufacturer			
Are you a first responder with the police?			
Are you a firefighter?			
Are you a swine worker?			
Are you a poultry worker?			
Do you have a chronic condition?			
Do you have a cardiac or pulmonary disorder (including bronchopulmonary dysplasia, cystic fibrosis and asthma)?			
Do you have diabetes mellitus or other metabolic diseases?			
Do you have cancer, immunodeficiency, or immunosuppression (due to underlying disease and/or therapy)?			
Do you have renal disease?			
Do you have anemia or hemoglobinopathy?			
Do you have conditions that compromise the management of respiratory secretions and are associated with an increased risk of aspiration?			
Are you a child or adolescent with conditions treated for long periods with acetylsalicylic acid?			
Are you a household contact/caregiver to an infant less than 6 months old, or a household contact/caregiver to anyone who is immunocompromised?			
Are you a pregnant woman?			
Do you have a fever?			
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?			
Are you allergic to any of the vaccine components?			
Have you experienced Guillain-Barre syndrome within 8 weeks of receiving a previous influenza vaccine?			
Do you have a history of seizures or fainting?			
Are you on any medication?			

In providing the information in this form, I confirm that I have read the Pandemic H1N1 Influenza Vaccine Fact Sheet provided and I understand the benefits, risks and possible reactions after vaccination. I have also had an opportunity to ask questions and have had them addressed to my satisfaction. I consent for the vaccine to be given. I have been advised to wait 15 minutes following injection to be observed for any potential adverse reactions.

Signature: ______________________ Date: ______________

Nursing Interventions (√ to indicate completed):

- ☐ Fact sheet provided to the client or parent for review prior to immunization
- ☐ Reviewed the screening questions with the client
- ☐ Client given an opportunity to ask questions and questions were addressed
- ☐ After care sheet completed, reviewed and provided to the client

Adjuvanted Vaccine

Antigen Lot Number	Adjuvant Lot Number	Dose	Route	Site	
		mL	IM	Rt Lt	Arm Thigh

Unadjuvanted Vaccine

Vaccine Lot Number	Dose	Route	Site	
	mL	IM	Rt Lt	Arm Thigh

Date: ___________________ **Time**: ______________ **Nurses Signature**: ______________________________

PROGRESS NOTES

Date & Time	SOAIP	S – family/individual/group perception of problem O – nurses observations A – assessment I – intervention P – plan of action