H1N1 VACCINE ADMINISTRATION CONSENT FORM

INFORMATION ABOUT PERSON RECEIVING VACCINE

PLEASE PRINT

LAST NAME_____ **FIRST NAME**_____ **M.I.**___

ADDRESS_____ **CITY/ST.** _____ **ZIP**_____

COUNTY _____ **DATE OF BIRTH**_____ **AGE**_____

PHONE #_____ **NAME OF PATIENT'S PHYSICIAN**_____

I have read or had explained to me the information in the Vaccine Information Statement (VIS) about the H1N1 vaccine administered. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and the risks of the vaccine. The authorized signature below allows the authorized personnel at the Clinton County Health Department to administer the H1N1 Vaccine.

X_____ **X** _____

Signature of patient or parent/guardian of minor **Date statement provided**

FOR CLINIC USE ONLY

H1N1 VACCINE (VIS date: 10/2/09) Date given_____ Manufacturer _____

Lot # _____ Site _____

NURSE'S SIGNATURE_____ **DATE**_____