

AREPANRIX™ Vaccine Consent Form
Pandemic H1N1 Influenza Vaccine (Adjuvanted) 2009-2010



OHCN (Health Card Number) _____ - _____ - _____ VC _____

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City: _____ Postal Code: _____ Home Phone: _____

Date of Birth: ____/____/____ Age: ____ Gender: Male Female
 yyyy mm dd

Email address: _____ Family Physician/Nurse Practitioner: _____

Name of School or Daycare (if attending): _____

CHECK ALL THAT APPLY

Is the person receiving the vaccine a:

- health care worker involved in/from a:
 - ___ pandemic response/essential health care services
 - ___ acute care
 - ___ chronic care
 - ___ ambulatory/community care
 - ___ emergency medical services
 - ___ laboratory
 - ___ public health
 - ___ pharmacy
 - ___ vaccine manufacturers
- person living 350 km or more from medical care
- first responder with the police
- firefighter
- swine worker
- poultry worker
- pregnant woman
- household contact/caregiver to an infant less than 6 months old
- household contact/caregiver to anyone who is immunocompromised

Does the person receiving the vaccine have a:

- chronic condition:
 - ___ cardiac or pulmonary disorder
 - ___ diabetes mellitus or other metabolic disease
 - ___ cancer, immunodeficiency, or immunosuppression
 - ___ renal (kidney) disease
 - ___ blood, bleeding disorder, anemia, hemoglobinopathy
- condition that compromises management of respiratory secretions, or increases risk of aspiration
- condition treated for long periods with acetylsalicylic acid

Has the person receiving the vaccine had:

- an allergy to:
 - ___ eggs or egg products
 - ___ thimerosal (in vaccines and contact lens solution)
- a hospitalization due to ORS*

Has the person received a flu vaccine before? No Yes

If yes: When? ____/____/____ (yyyy/mm/dd)
 Was it pH1N1 vaccine? No Yes
 Any problems receiving the vaccine? No Yes

I further confirm that I have read the H1N1-2009 Influenza Fact Sheet and understand the benefits and possible risks of the vaccine. Any questions I had were answered to my satisfaction. I have been advised to wait 15 minutes following injection to be observed for any potential adverse reactions. I am providing consent for myself (the above-named) to be vaccinated against the flu.

Name of person completing form if different from above: _____

Relationship to above: _____

Signature of client/parent/guardian: _____ **Date:** ____/____/____
 yyyy mm dd

If signing for someone other than yourself, you must be the appropriate substitute decision maker.

Contact in case of emergency: _____ Phone: _____

Notice of Collection: Personal information is collected under the authority of the Health Protection and Promotion Act R.S.O. 1990, to maintain a record of your immunization and to provide statistics required by the Peterborough County-City Health Unit and the Ministry of Health and Long-Term Care. Should you have questions about the collection and maintenance of this information, please contact **Dr. Rosana Pellizzari at 705-743-1000 ext. 264**

FOR VACCINATOR'S USE ONLY WHEN ELECTRONIC CLINIC MANAGEMENT IS NOT USED

- | | | | |
|---|-----------------------------|------------------------------|--------------------------------|
| Are you feeling ill today? fever? infection? | No <input type="checkbox"/> | Yes <input type="checkbox"/> | If yes, please explain below |
| Have you ever had a flu shot before? | No <input type="checkbox"/> | Yes <input type="checkbox"/> | |
| If yes, did you have any problems after the shot? | No <input type="checkbox"/> | Yes <input type="checkbox"/> | If yes, please explain below |
| Have you ever had an allergic reaction to a vaccine? | No <input type="checkbox"/> | Yes <input type="checkbox"/> | If yes, please explain below |
| Are you allergic to: eggs or egg products? | No <input type="checkbox"/> | Yes <input type="checkbox"/> | If yes, please explain below |
| thimerosal - in vaccines and contact lens solution | No <input type="checkbox"/> | Yes <input type="checkbox"/> | If yes, please explain below |
| Do you think you are or may be pregnant? | No <input type="checkbox"/> | Yes <input type="checkbox"/> | If yes, indicate how far along |
| Do you have a blood disorder? | No <input type="checkbox"/> | Yes <input type="checkbox"/> | If yes, please explain below |
| Are you taking any medication that could affect blood clotting? | No <input type="checkbox"/> | Yes <input type="checkbox"/> | If yes, please explain below |
| Have you ever been diagnosed with Guillain-Barré Syndrome? | No <input type="checkbox"/> | Yes <input type="checkbox"/> | If yes, please explain below |
| Did you read the information provided to you? | No <input type="checkbox"/> | Yes <input type="checkbox"/> | |

Please explain any "Yes" answers provided above: _____

Health history reviewed: ___Yes ___ No **Vaccine administered:** Arepanrix, GlaxoSmithKline

Adjuvant Lot #: _____ **Antigen Lot #:** _____ **Site:** ___deltoid ___quad ___right ___left

Dose: _____ ml **Date:** _____ **Time:** _____ hrs.

Vaccinator Initials: _____ **Vaccinator Signature:** _____ **Designation:** _____