

# Pandemic H1N1 (pH1N1) INFLUENZA Vaccine

**NOTE: You must remain in the clinic area 15 minutes after the needle is given.**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth: Year \_\_\_\_\_ Month \_\_\_\_\_ Day \_\_\_\_\_ Age \_\_\_\_\_

Address: \_\_\_\_\_  
 Unit/Apt.# \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ Postal Code \_\_\_\_\_

Telephone: Day: ( ) \_\_\_\_\_ Evening: ( ) \_\_\_\_\_

**Allergies:** No  Yes   
 If Yes, please list: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Previous "Flu Shot":** No  Yes   
 Have you ever had any previous side effects to a flu vaccine or any other vaccine?  
 \_\_\_\_\_  
 \_\_\_\_\_

**Please complete:**  
 Male  Female   
 Age  
 6 months to 5 yrs   
 6 - 18 yrs.   
 19 - 64 yrs.   
 65 or over

**Please read information on back of this consent form.** I have read the information about the pH1N1 influenza vaccine. I have had the chance to ask questions which were answered to my satisfaction. I understand the benefits and risks associated with this vaccine. I give consent to Ottawa Public Health to administer the flu vaccine.

Signature: X \_\_\_\_\_ Date: \_\_\_\_\_

Note: Parent's or legal guardian's signature required if child is 13 years of age or under. Also, children 13 years of age and under must be accompanied by their parent or legal guardian.

**For Clinic Use Only**

Type of Vaccine:  
 Arepanrix™/AS03 adjuvant:  \_\_\_\_\_  
 Lot Number \_\_\_\_\_

Influenza A (H1N1)-2009 Monovalent vaccine (without adjuvant):  \_\_\_\_\_  
 Lot Number \_\_\_\_\_

0.5 ml intramuscular       0.25 ml intramuscular   
 (6 months to 9 years of age)

Right-Left Arm       Right-Left Thigh

Date/Time \_\_\_\_\_

Registered Nurse's Signature \_\_\_\_\_ Registered Practical Nurse's Signature \_\_\_\_\_

Comments \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Personal information is collected under the legal authority of sections 2 and 5 of the Health Protection and Promotion Act, R.S.O. 1990, c.H.7 for the purpose of maintaining an immunization record for this individual. Ottawa Public Health, except for information required by the Ministry of Health and Long-Term Care, will maintain it in confidence. Should you have questions about the collection and maintenance of this information, please contact Ottawa Public Health.

**Pandemic H1N1 influenza vaccination screening tool**

First name: _____
Last name: _____

Please answer the following questions		NO	YES
1	Do you have a fever?	<input type="checkbox"/>	<input type="checkbox"/>
2	Have you received the 2009 seasonal flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
3	Are you from a remote community (350km or more from access to any medical care)?	<input type="checkbox"/>	<input type="checkbox"/>
4	Are you a health care worker involved in the pandemic response or delivering essential health care services (includes full-time, part-time, students and volunteers)?	<input type="checkbox"/>	<input type="checkbox"/>
5	- Acute Care?	<input type="checkbox"/>	<input type="checkbox"/>
6	- Chronic Care?	<input type="checkbox"/>	<input type="checkbox"/>
7	- Ambulatory/Community Care?	<input type="checkbox"/>	<input type="checkbox"/>
8	- Emergency Medical Services?	<input type="checkbox"/>	<input type="checkbox"/>
9	- Laboratory?	<input type="checkbox"/>	<input type="checkbox"/>
10	- Public Health?	<input type="checkbox"/>	<input type="checkbox"/>
11	- Pharmacies?	<input type="checkbox"/>	<input type="checkbox"/>
12	- Vaccine Manufacturers?	<input type="checkbox"/>	<input type="checkbox"/>
13	Are you a first responder with the police?	<input type="checkbox"/>	<input type="checkbox"/>
14	Are you a firefighter?	<input type="checkbox"/>	<input type="checkbox"/>
15	Are you a swine worker?	<input type="checkbox"/>	<input type="checkbox"/>
16	Are you a poultry worker?	<input type="checkbox"/>	<input type="checkbox"/>
17	Do you have a chronic condition?	<input type="checkbox"/>	<input type="checkbox"/>
18	Do you have a cardiac or pulmonary disorder (including bronchopulmonary dysplasia, cystic fibrosis and asthma)?	<input type="checkbox"/>	<input type="checkbox"/>
19	Do you have a diabetes mellitus or other metabolic diseases?	<input type="checkbox"/>	<input type="checkbox"/>
20	Do you have cancer, immunodeficiency, or immunosuppression (due to underlying disease and/or therapy)?	<input type="checkbox"/>	<input type="checkbox"/>
21	Do you have renal disease?	<input type="checkbox"/>	<input type="checkbox"/>
22	Do you have anemia or hemoglobinopathy?	<input type="checkbox"/>	<input type="checkbox"/>
23	Do you have conditions that compromise the management of respiratory secretions and are associated with an increased risk of aspiration?	<input type="checkbox"/>	<input type="checkbox"/>
24	Are you a child or adolescent with conditions treated for long periods with acetylsalicylic acid?	<input type="checkbox"/>	<input type="checkbox"/>
25	Are you a pregnant woman?	<input type="checkbox"/>	<input type="checkbox"/>
26	Are you a household contact/caregiver to an infant less than 6 months old, or a household contact/caregiver to anyone who is immunocompromised?	<input type="checkbox"/>	<input type="checkbox"/>
27	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?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Are you allergic to any of the following:</b>			
28	Egg or egg products	<input type="checkbox"/>	<input type="checkbox"/>
29	Thimerosal	<input type="checkbox"/>	<input type="checkbox"/>
30	Do you identify with an ethnic group such as: <input type="checkbox"/> First Nations <input type="checkbox"/> Inuit <input type="checkbox"/> Métis <input type="checkbox"/> Other _____		

Revised: November 2009

