



AREPANRIX™ CONSENT FORM
PANDEMIC H1N1 INFLUENZA VACCINE (ADJUVANTED) 2009-2010

Last name: _____ First name: _____

Male

Female

Date of Birth: ____/____/____

Year/Month/Day

For children **6 months of age to less than 10 years of age**, is this the first or second dose of Arepanrix™? (*Let the nurse know if your children received a Pandemic H1N1 influenza vaccine OTHER than Arepanrix™*).

First

Second If second, please indicate the date of the first dose: ____/____/____
Year/Month/Day

I have read (or it has been read to me) and I understand the "2009 Pandemic H1N1 Influenza Vaccine Fact Sheet". I have had the opportunity to ask questions and to have them answered to my satisfaction. I consent to the Arepanrix™ vaccine.

Signature: _____ Print Name: _____ Date: _____

If signing for someone other than yourself, you must be the appropriate substitute decision maker (those who are deemed not to be capable of providing their own consent require parental consent or the consent of a legal guardian before receiving the vaccine).

If signing for someone other than yourself, indicate your relationship to that other person: _____

For Clinic Use Only:

Vaccine	Dose (circle dose given)	Site	Combined Lot Number	Date Given	Time Given	Given By
Arepanrix™	0.25 mL IM					
	0.50 mL IM					

Comments:

Notice of Collection: Personal information is collected under the authority of the Health Protection and Promotion Act R.S.O. 1990. It is collected to maintain a record of your immunization and to provide statistics required by the Leeds, Grenville and Lanark District 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 **Jane Futcher, Director of Clinical Services at 613-345-5685 ext. 2236.**

PANDEMIC H1N1 INFLUENZA VACCINATION SCREENING TOOL

Do you have any of the following:		
	YES	NO
Have you received the 2009 Seasonal Flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
Are you from a remote community (350km or more from access to any medical care)?	<input type="checkbox"/>	<input type="checkbox"/>
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"/> Acute Care? <input type="checkbox"/> Laboratory? <input type="checkbox"/> Ambulatory/Community Care? <input type="checkbox"/> Chronic Care? <input type="checkbox"/> Public Health? <input type="checkbox"/> Pharmacies? <input type="checkbox"/> Emergency Medical Services? <input type="checkbox"/> Vaccine Manufacturers?	<input type="checkbox"/>	<input type="checkbox"/>
Are you a first responder with the police?	<input type="checkbox"/>	<input type="checkbox"/>
Are you a firefighter?	<input type="checkbox"/>	<input type="checkbox"/>
Are you a swine worker?	<input type="checkbox"/>	<input type="checkbox"/>
Are you a poultry worker?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a chronic condition?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a cardiac or pulmonary disorder (including bronchopulmonary dysplasia, cystic fibrosis and asthma)?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a diabetes mellitus or other metabolic diseases?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have cancer, immunodeficiency, or immunosuppression (due to underlying disease and/or therapy)?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have renal disease?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have anemia or hemoglobinopathy?	<input type="checkbox"/>	<input type="checkbox"/>
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"/>
Are you a child or adolescent with conditions treated for long periods with acetylsalicylic acid?	<input type="checkbox"/>	<input type="checkbox"/>
Are you a pregnant woman?	<input type="checkbox"/>	<input type="checkbox"/>
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"/>