

Client ID :

Vaccination Centre Name : _____ LHO Area : _____

- Please read the attached Pandemic H1N1 (Swine Flu) Information
- Please answer the questions and sign the consent form below (using black pen and block capitals)
- **Parents / Guardians please note—students aged 16 years and older may sign their own consent form.**

First Name: _____ Surname: _____
 Address: _____

 Postal Code/County: _____ PPS Number: _____
 DOB: (dd/mm/yyyy) ____/____/____ AGE: _____ Male Female
 Parent Name/ Contact Phone No. _____

School/college: _____ Class/Year: _____
 GP Name: _____
 Address: _____ Contact Number: _____

Are you /your daughter in the first 14 weeks of pregnancy? Yes No
 Has the person getting vaccinated any serious illness? Yes No
 If yes, please specify _____
 Have you /your child got any haematological/bleeding disorder? Yes No
 Have you/ your child ever had a serious reaction (allergy) to any vaccine component e.g. Eggs, Formaldehyde, Gentamycin, Thiomersal? Yes No
 Have you / your child a history of Guillian B rre Syndrome? Yes No
 Has the person being vaccinated previously received Swine Flu vaccine? Yes No

I have read and understand the fact sheet.
 I CONSENT to be / for the above named child to be vaccinated with two doses of a Pandemic (H1N1) 2009 flu vaccine.
 Signature : _____
 (Self/Mother/Father/Legal Guardian)
 Circle Appropriate
 Date: / /

I have read and understand the fact sheet.
 I REFUSE consent to be / for the above named child to be vaccinated with two doses of a Pandemic (H1N1) 2009 flu vaccine
 Signature: _____
 (Self/Mother/Father/Legal Guardian)
 Circle Appropriate
 Date: / /

Staff are aware of their obligations under the Data Protection Acts, 1988 and 2003. The information provided on this form will be used for the purposes of health care provision and provider payment purposes only.

FOR OFFICE USE ONLY

Increased Medical Risk Yes Codes (Circle all that apply) a b c d e f g h i j k

| Date Given | Batch No. | Manufacturer | Dose Given | Site Given | Prescribed by Signature & MCRN | Vaccinator's Signature & MCRN/Nurse PIN |
|-----------------|-----------|--------------|------------|------------|--------------------------------|---|
| Pandemic Dose 1 | | | | | | |
| Date Given | Batch No. | Manufacturer | Dose Given | Site Given | Prescribed by Signature & MCRN | Vaccinator's Signature & MCRN/Nurse PIN |
| Pandemic Dose 2 | | | | | | |

Not Vaccinated Reason not vaccinated code: (circle as appropriate) A B C D
 Record Card Given : Date Updated on IT System : / /

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Please tick on front of page if **Increased Medical Risk Patient** and circle all appropriate codes

e.g. Patient is in an **Increased Medical Risk Group** and has **Chronic Respiratory Disease**, is **pregnant (2nd and 3rd trimester)** and has **Chronic Liver Disease**

This is coded as (a), (b) (e)

Increased Medical Risk Code

- a) Chronic Respiratory Disease (including all who received any medical treatment for asthma in past 3 years)
- b) Pregnant women
- c) Chronic Heart Disease
- d) Chronic Renal Disease
- e) Chronic Liver Disease
- f) Chronic Neurological Disease
- g) Immunosuppressed
- h) Household Contacts of Immunosuppressed and household contacts of those < 6 months
- i) Diabetes Mellitus
- j) Morbidly Obese
- k) Haemoglobinopathies

Vaccination under Medication Protocol

If answer yes to any of the following please refer for individual medical assessment prior to vaccination

Is patient in first 14 weeks of pregnancy? Yes No

Is there a contraindication to IM Injection?
(Haematological disorder/bleeding disorder) Yes No

Is patient allergic to any of the vaccine components?
(Eggs, Formaldehyde, Gentamycin etc.) Yes No

Is there a history of Guillain Barré Syndrome? Yes No

Referred for individual medical assessment ? Yes

Adverse Reaction? Yes Adverse Reaction Form Completed? Yes

Incident (including anaphylaxis or medication error/near miss) Yes

Incident Form Completed? Yes

Please tick on front of page if patient not vaccinated and circle appropriate code

- A) Vaccination contraindicated
- B) Vaccination deferred
- C) Vaccine refused
- D) Left prior to being vaccinated