



Department of Health

PO Box 2000, Charlottetown
Prince Edward Island
Canada C1A 7N8

Name:
Health #: Or Addressograph
DOB:

Pandemic Influenza Vaccine
Consent and Record of Immunization

I have read or had explained to me the information on the H1N1 vaccine and understand the risks, benefits and side effects. I have had a chance to ask questions/express my concerns and have been provided sufficient response. I consent to have the pandemic H1N1 influenza vaccine given to me or my dependent at this time.

Signature (self or parent/guardian) Relationship to dependent if applicable Date, 2009

Statement on Surveillance Information

The information below is collected for surveillance purposes only and will not be used to identify individuals. Summary statistics will be produced from the total information.

Gender: Male [] Female []

Age: (if less than 1 year) ___ years ___ months

Do you have a health condition requiring regular visits to doctor? Yes [] No []

Are you pregnant or considering becoming pregnant within one month? Yes [] No []

Are you a Health Care Worker? Yes [] No []

Do you identify as First Nations? Yes [] No []

Screening by Nurse

Dose: 1 [] 2 []

Type: Adjuvanted [] Unadjuvanted []

Are you/your dependent sick or do you have a fever today? Yes [] No []

Do you/your dependent have any serious allergies, including egg, that you know of? Yes [] No []

Have you or your dependent ever had a serious reaction to a previous dose of vaccine? Yes [] No []

Have you or your dependent ever developed Guillain-Barré Syndrome? Yes [] No []

Lot # _____ Vaccine Dosage (IM): []0.5 ml []0.25ml

Injection site: []deltoid []vastus lateralis

Name of person giving vaccine _____ (PRINT) (SIGNATURE)