H1N1 INFLUENZA VACCINATION CONSENT FORM

********PLEASE PRINT********

FIRST NAME________________________________

LAST NAME_________________________________

DATE OF BIRTH_____________________________

ADDRESS __________________________________

CITY______________________ ZIP______________

CHECK THE CATEGORY THAT APPLIES TO YOU:

____ PREGNANCY

____ HOUSEHOLD CONTACT /CAREGIVER FOR INFANTS YOUNGER THAN 6 MONTHS OF AGE

____ HEALTHCARE AND EMS PERSONNEL

____ PEOPLE FROM 6 MONTHS THROUGH 24 YEARS OF AGE

____ PERSONS AGED 25 THROUGH 64 YEARS WHO HAVE HEALTH CONDITIONS ASSOCIATED WITH HIGHER RISK OF MEDICAL COMPLICATIONS FROM INFLUENZA

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SIGNATURE DATE