HAVERFORD

HAVERFORD COLLEGE HEALTH SERVICES
H1N1 CONSENT

NAME:____
(Last) (First) Please Print

ADDRESS:____

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TELEPHONE:____

DO YOU FEEL YOUR USUAL SELF TODAY: (circle) YES NO
ARE YOU ALLERGIC TO EGGS: (circle) YES NO
HAVE YOU EVER HAD A REACTION TO THE FLU VACCINE (circle) YES NO

I HAVE NONE OF THE CONTRAINDICATIONS LISTED BELOW:

1. Allergies (especially to eggs and/or egg products) or sensitivity to thimerosal.
2. A cold or fever at this time
3. A recent vaccine immunization
4. Any reaction to a similar vaccine in the past
5. A history of neurological disorders

I AM ALSO AWARE THAT THERE MAY BE A MILD REACTION SUCH AS MILD FEVER, HEADACHE, OR BODY ACHES. IN RARE INSTANCES THERE CAN BE MORE SEVERE REACTIONS SUCH AS ACUTE RESPIRATORY DISTRESS, COLLAPSE, AND/OR PARALYSIS.

I GIVE PERMISSION FOR HAVERFORD COLLEGE HEALTH SERVICES TO ADMINISTER H1N1 VACCINE TO ME. I HEREBY RELEASE THE HAVERFORD COLLEGE HEALTH SERVICES STAFF FROM ANY LIABILITY RESULTING FROM THE H1N1VACCINE TO ME. I HAVE BEEN ADVISED TO INFORM MY HEALTHCARE PROVIDER ABOUT RECEIVING THIS VACCINATION.

______________________ ______________________
SIGNATURE DATE

______________________ NASAL SPRAY 500824P 15-MARCH-2010
RN SIGNATURE SITE LOT NO. – EXP. DATE