Please Print Clearly

Last Name ______________________________ First Name ______________________________

Date of Birth ____________________ Sex: ☐ Male ☐ Female

Address: County of Residence ____________________________________

Street ____

City ____________________________________ State ______________________

Zip Code _______________ Phone (__________)______________________________

By signing below I verify: I have read or had explained to me the Vaccine Information Statement for the H1N1 influenza Vaccine and understand the risk and benefits. I consent to the administration of the H1N1 vaccine to me or the person to whom I am authorized to make this request.

____________________________________ ______________________________

Signature of Client or Representative Relationship to client

____________________________________ ______________________________

Printed Name of Person Signing Date