

# H1N1 VACCINE ADMINISTRATION RECORD

Revised 10.16.09

<b>Person to receive vaccine. (Please print)</b>					
<b>Last</b>	<b>First</b>	<b>Middle Initial</b>	<b>Birthdate</b>	<b><i>And</i></b>	<b>Age</b>
<b>Address</b>	<b>City</b>	<b>County</b>	<b>State</b>	<b>Zip</b>	
<b>Cell, Home or Work Phone:</b>	<b>Gender</b>	<input type="checkbox"/> M <input type="checkbox"/> F	<b>Social Security #:</b>		
<b>Race:</b> <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Native American <input type="checkbox"/> Asian <input type="checkbox"/> Other			<b>Ethnicity:</b> <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic		
<b>The 11 questions listed below are for screening purposes only and will help us determine if the person named above can receive the 2009 H1N1 vaccine and which type (Injectable or Nasal). Please circle Yes or No.</b>					
<b>Is/Does the person receiving the vaccine today:</b>					
1. Sick/ running a fever?			YES	NO	
2. Have a serious allergy to eggs?			YES	NO	
3. Have any other serious allergies? Please list:			YES	NO	
4. Ever had a serious reaction or allergic response to past flu vaccinations?			YES	NO	
5. Ever had Guillian-Barre syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?			YES	NO	
<b>There are two types of 2009 H1N1 influenza vaccine (Injectable or Nasal Spray). Your answers to the following questions will help us know which of the two kinds of vaccine you can receive.</b>					
6. Received any other vaccines within the last 4 weeks? (For example nasal spray influenza, MMR, varicella, etc.) Vaccine(s): _____ Date received: _____			YES	NO	
7. Have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves or blood?			YES	NO	
8. A child or adolescent on long-term aspirin or aspirin-containing therapy (for example, does your child take aspirin every day)?			YES	NO	
9. Have a weakened immune system (for example, from HIV, cancer, or medications such as steroids)?			YES	NO	
10. Pregnant?			YES	NO	
11. Have close contact with a person whose immune system is severely compromised and who must be in a protective isolation (such as in a hospital room with reverse air flow)?			YES	NO	
<p>I have read or had explained to me the information about influenza and influenza vaccine. I have had my questions answered to my satisfaction. I understand the benefits and risks of influenza vaccine and approve the vaccine be administered to me or the person named above for whom I am authorized to make this request. <b>If Applicable, Billing and Release of Information Authorization:</b> I authorize the release of any medical or other information necessary to process this claim. I also request payment for medical benefits described below to the Kenosha County Division of Health.</p> <p>X _____ Date _____ Signature of self/guardian</p>					

\*\*\*\*\* For Clinic/Office Use \*\*\*\*\*

PH Clinic \_\_\_\_\_

Date Vaccinated \_\_\_\_\_

<b>Route (circle one):</b> IM or Intranasal (IN)	<b>Body Site (circle one):</b> RD RV LD LV IN
<b>Dose number (circle one):</b> 1 or 2	<b>Dose Amount (circle one):</b> .25 ml or .5ml
<b>Manufacturer (circle one):</b> SP Novartis CSL GSK MedImmune	<b>Lot #</b> _____
<b>Signature of Vaccinator:</b> _____	<b>Date:</b> _____

Client ID#: _____	Time: _____	Amount Paid: _____
Financials/Demographics Complete: _____	Contraindications Checked: _____	Entered into WIR: _____