

2009 Novel H1N1 Influenza Form 2009-2010

PLEASE PRINT CLEARLY WITH BLOCK LETTERS
USING A BLUE OR BLACK MEDIUM POINT INK PEN

A B C 1 2 3

MALE FEMALE

Last Name

Initial First Name

Date Of Birth

Street Address 1

Apt #

Street Address 2 (if needed)

County

City

State

Zip Code

Mark one:

Medicare Medicaid Other Insurance

Specify if Other Insurance

Insurance Number

Group Number

Do any of the following apply to the person named above:

YES NO

1. Ever had a serious allergic reaction to eggs or anything else? Please List:	<input type="checkbox"/>	<input type="checkbox"/>
2. Ever had a serious reaction to a previous dose of flu vaccine or developed Guillain-Barre' Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
3. Received any vaccination (not just flu) within the past 30 days?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have asthma, diabetes (or other type of metabolic disease), or disease of lungs, heart, kidneys, liver, nerves or blood?	<input type="checkbox"/>	<input type="checkbox"/>
5. On long-term aspirin or aspirin-containing therapy (for example, taking aspirin every day)?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have a weak immune system (for example, from HIV, cancer, or medications such as steroids)?	<input type="checkbox"/>	<input type="checkbox"/>
7. In close contact with a person who needs care in a protected environment (for example, someone who recently had a bone marrow transplant)?	<input type="checkbox"/>	<input type="checkbox"/>
8. Currently pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
9. Been told in the past 12 months by a health care provider that they had one or more episodes of wheezing?	<input type="checkbox"/>	<input type="checkbox"/>

I give permission for myself or the above named child to receive vaccine for the 2009 novel H1N1 virus. I understand/authorize the following:

- All medical records are strictly confidential. Medical records may be used for audit and statistical purposes.
- The vaccine itself is provided free. An administration fee may be billed to my insurance (for example, private insurance, Medicaid, or Medicare) using my protected health information.
- If I do not have insurance, I may be personally charged the administration fee but if I cannot afford it, the fee will not be charged or I will be referred to a clinic that does not charge.
- NOTE: individuals will not be charged the administration fee at vaccine clinics in public schools or health departments.
- I have been offered a copy of the provider's Notice of Privacy Practices.
- I have read and understand the Vaccine Information Statement and have had the opportunity to discuss it with the provider.

Authorization Signature

Date

OFFICE USE ONLY

Date Vaccine and VIS Given

Date of VIS

Clinic Site (Assigned Number)

LA	RA	LT	RT	IM	NASAL	1	2
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Site of Injection				Route		Dose	

Manufacturer and Lot Number

Print or Stamp Site Name

Signature of Provider/Vaccinator