

2009-2010 H1N1 VACCINE ADMINISTRATION RECORD

(10 years and over)

INFORMATION ABOUT PERSON TO RECEIVE VACCINE *(please print)*:

LAST NAME: _____ FIRST: _____

ADDRESS: _____ VIL/TWP: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ BIRTHDATE: _____ AGE: _____ SEX: M F

Your answers to the following questions will help us decide which vaccine, injectable or nasal spray, is appropriate for you. (A vaccine administrator can assist you with any concerns when vaccine given)

All individuals please answer questions 1 – 5:

| | | |
|---|---|---|
| 1. Are you ill with a fever today? | N | Y |
| 2. Have you ever had a serious reaction to an influenza vaccine in the past? | N | Y |
| 3. Are you allergic to eggs, thimerosal, or any other component of the flu vaccine? | N | Y |
| 4. Were you ever paralyzed with Guillain-Barre Syndrome (also called GBS)? | N | Y |
| 5. Females: Are you pregnant? | N | Y |
| If pregnant: Prescription order is needed from physician | | |

Healthy individuals 49 years and under requesting the nasal spray please answer questions 6-10:

| | | |
|--|---|---|
| 6. Have you received a live virus vaccine in the past 30 days? | N | Y |
| 7. Are you allergic to egg proteins, gentamicin, gelatin, or arginine? | N | Y |
| 8. Do you have wheezing, asthma, diabetes, anemia, or long term health problems? | N | Y |
| 9. Do you or a close contact have a <i>severely</i> weakened immune system? | N | Y |
| 10. Have you received anti-viral treatment within the past 48 hours? | N | Y |
| 11. 10-17 years old: Taking any aspirin or aspirin-containing therapy? | N | Y |

I have read or have had explained to me the **H1N1** Vaccine Information Statement. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the influenza vaccine, and ask that the vaccine be given to me or my dependent.

I hereby acknowledge that I have been offered a copy of the Geauga County Health District's "Notice of Privacy Practices", which provides information on how my health information may be used and disclosed, and my rights with respect to my health information. A copy is available at www.geaugacountyhealth.org or call 440-279-1950 for assistance.

Signature: _____ **Date:** _____
Person receiving vaccine or authorized person (Parent or Guardian)

DO NOT WRITE BELOW THIS LINE

TO BE COMPLETED BY HEALTH DISTRICT STAFF ONLY

| | | | | | |
|--------------|--|-----------------------------|-------|-------------|---|
| Clinic Name: | | | | | |
| Date: | Dose & Site: .5cc IM RD LD 0.2 mL Intranasal | MFG: Sanofi MedImmune | Lot#: | Expiration: | Vaccine Administrator Signature & title: |
| | | | | | VIS Date: 10/2/2009 |
| Notes: | | | | | |