2009-2010 Pediatric H1N1 VACCINE ADMINISTRATION RECORD

(6 months through 9 years)

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 parents/guardians please answer questions 1 – 5 regarding the child:

Question		
1. Any fever today?	N	Y
2. Serious reaction to an influenza vaccine in the past?	N	Y
3. Allergic to eggs, thimerosol, or any other component of the flu vaccine?	N	Y
4. Paralyzed with Guillain-Barre Syndrome (also called GBS)?	N	Y
5. Had H1N1 flu vaccine this year? **If yes,** Date: **Circle:** Nasal Spray or Shot	N	Y

Healthy 2 years through 9 years old for nasal spray please answer questions 6 – 10 for the child:

Question		
6. Received a live virus vaccine in the past 30 days?	N	Y
7. Allergic to egg proteins, gentamicin, gelatin, or arginine?	N	Y
8. Any wheezing, asthma, diabetes, anemia, or long term health problems	N	Y
9. Close contact have a *severely* weakened immune system?	N	Y
10. Received anti-viral treatment within the past 48 hours?	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 DISRICT STAFF ONLY

Clinic Name:							
Date:	Dose & Site: .25cc IM RL LL .5cc IM RL LL RD LD 0.2mL Intranasal	MFG: Sanofi MedImmune	Lot#:	Expiration:	Vaccine Administrator Signature & title:	VIS Date: 10/2/2009
Date:	Dose & Site: .25cc IM RL LL .5cc IM RL LL RD LD 0.2 mL Intranasal	MFG: Sanofi MedImmune	Lot#:	Expiration:	Vaccine Administrator Signature & title:	VIS Date: 10/2/2009
Notes:						