

H1N1 (SWINE) FLU VACCINE ADMINISTRATION RECORD INACTIVATED (H1N1 SHOT)

Risk Factor: _____

| | |
|--|---|
| H1N1(SWINE) INFLUENZA 3 yrs + Manufactured by: Novartis <input style="width: 50px;" type="text"/> Lot: 102137P1 Expiration date 3/31/2010 Vaccine Administered: Site of Injection: RIGHT LEFT <div style="text-align: center;"> DELTOID THIGH </div> | <input style="width: 100%; height: 100%;" type="text"/> |
|--|---|

FOR OFFICE/CLINIC USE ONLY

Clinic/Office Address Macon County Health Department, 1221 E. Condit, Decatur, IL

Signature of Vaccine Administrator _____

Title of Vaccine Administrator Registered Nurse/LPN

INFORMATION ABOUT PERSON TO RECEIVE VACCINE

Please Print

| | | | | |
|----------------|--------|----------------|-----------|-------------|
| Last name | First | Middle Initial | Birthdate | Age |
| | | | | |
| Street Address | City | Zip Code | County | Telephone # |
| | | | | |
| Male | Female | | | |

I have read or have had explained to me the information in the Vaccine Information Sheet about the H1N1 INACTIVATED Influenza Vaccine (10/02/2009). I have had a chance to ask questions and these have been answered to my satisfaction. I believe I understand the benefits and risks of the H1N1 INACTIVATED Influenza Vaccine and ask that the selected vaccine/vaccines be given to me or the persons named above for who I am authorized to make this request. I accept responsibility for seeking medical attention for any problems with this vaccination. I authorize billing of this/these vaccination to Medicare/Medicaid. I give permission for the Macon County Health Department to release the date of this vaccine to my physician or any other health care provider needing this information. Signature of person to receive the influenza vaccine, or the person authorized to make request. I do hereby consent to allow the Macon County Health Department to provide the immunizations requested.

X _____ Date _____

| | | | | |
|---|---|---|---|---|
| Medicaid | Medicare | Cash | Check # _____ | NO |
| <input style="width: 50px; height: 30px;" type="text"/> | <input style="width: 50px; height: 30px;" type="text"/> | <input style="width: 50px; height: 30px;" type="text"/> | <input style="width: 50px; height: 30px;" type="text"/> | <input style="width: 50px; height: 30px;" type="text"/> |

Medicaid or Medicare # _____

Patient name: _____ Date of birth: ____/____/____
 (mo.) (day) (yr.)

Screening Questionnaire for Injectable Influenza Vaccination

For adult patients as well as parents of children to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child injectable influenza vaccination today. If you answer “yes” to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

| | Yes | No | Don't Know |
|--|--------------------------|--------------------------|--------------------------|
| 1. Is the person to be vaccinated sick today? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Has the person to be vaccinated ever had Guillain-Barré syndrome? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Form completed by: _____ Date: _____

Form reviewed by: _____ Date: _____