Reset Form

Influenza A (H1N1) Public Provider Vaccination Administration Record

PRINT in capital letters as shown here: EXAMPLE 123

Mark boxes like this: X

If you make a mistake, DARKEN the entire box ■ and "X" the correct one: X

Darken like this: ●
Not like this: ○ ⊗ ✓

Personal information: Provide information as completely as you can. All information will be kept confidential.

1. First Name of person receiving vaccination: janet
2. Last Name of person receiving vaccination: knewio

Home address of person receiving vaccine

3. Street Number: 3049
4. Street Name: minetaions
5. Apt No.:
6. City/Town: minnestiat
7. State: ct
8. Zip Code: 06283
9. Phone number where we can reach you or parent/guardian (if child): (860) 348-2222
10. DOB (mm/dd/yyyy): 01/30/1929
11. Age (years): 003
12. Months: If person receiving vaccine is <1 year old, please give age in months.

13. Race (optional): ○ White ○ Black or African American ○ Asian ○ Other ○ American Indian or Alaskan Native ○ Native Hawaiian or Pacific Islander
14. Hispanic or Latino? (optional): ○ Yes ○ No
15. Gender: ○ Male ○ Female

Screening Questions: please complete if you are receiving vaccine or have parent/guardian complete for a minor child. FILL IN CIRCLE

16. Does the person receiving vaccine (adult or child) live in a household with a child less than 6 months of age?	○ Yes ○ No
17. Is the person receiving vaccine (adult or child) pregnant or think they might be pregnant?	○ Yes ○ No
18. Is the person receiving vaccine (adult or child) allergic to eggs, thimerosal or other vaccine components?	○ Yes ○ No
19. Has the person receiving vaccine (adult or child) ever had a serious reaction to any vaccine?	○ Yes ○ No
20. Has the person receiving vaccine (adult or child) ever been diagnosed with Guillain-Barre Syndrome within 6 weeks of a previous influenza vaccination?	○ Yes ○ No
21. Is the person receiving vaccine (adult or child) sick with a fever today?	○ Yes ○ No

22. Does the person receiving vaccine (adult or child) have any of the following medical conditions? PUT AN 'X' IN EACH BOX THAT APPLIES, if none leave blank

☐ Asthma ☐ Cancer ☐ Heart Disease ☐ Kidney Disease ☐ Lung Disease
☐ Blood Disorder ☐ Diabetes ☐ Immune Disorder ☐ Liver Disease ☐ Neurological Disease

For persons receiving LAIV (live virus vaccine) only (if not receiving LAIV, skip to consent and leave blank): FILL IN CIRCLE

23. Does the person receiving vaccine (adult or child) have cancer, leukemia, AIDS, or any other immune system problem, or take cortisone, prednisone, other steroids, or anticancer drugs,or have they had radiation treatments or received a transfusion of blood/blood products or been given immune (gamma) globulin drugs in the past year?	○ Yes ○ No
24. If a child or adolescent, is the person receiving vaccine on long term aspirin therapy?	○ Yes ○ No
25. Has the person receiving vaccine (adult or child) taken antivirals within 48 hours prior to this visit or have they received a vaccine in the past 4 weeks?	○ Yes ○ No

PLEASE READ THE FOLLOWING AND SIGN BELOW. PARENT/GUARDIAN please sign for minor child and print your first and last names in the boxes below.
I have received the Influenza A (H1N1) Monovalent Vaccine Information Statement. I have had a chance to ask questions and I understand the benefits and risks of the vaccine. I request that the vaccination be given to me (or to the person for whom I am authorized to make this request). I authorize the release of any medical or other information necessary to process the insurance claim or for other public health purpose. I have received a copy of the Notice of Privacy Practices.

26. First Name of Parent/Guardian if child:
27. Last Name of Parent/Guardian if child:
28. Signature of person receiving vaccine or parent/guardian if a minor:

Once you sign the consent, you may stop. The person giving you the vaccine will complete the rest of the form.

STOP – DO NOT WRITE BELOW THIS LINE (vaccine administrator completes this section)

29. Insurance Information Needed? ○ Yes ◉ No
30. Insurance Company:
31. Insurance ID No.:
32. First and Last Name of Policy Holder (PLEASE PRINT):

33. Vaccine: INFLUENZA A H1N1
34. VIS publication date: 10/02/2009
35. If vaccine label available, place in box to the right. If no label completed information below (#40 - 42). place label here

36. Manufacturer: ○ Sanofi Pasteur ◉ GlaxoSmithKline ○ CSL Biotherapies ○ Novartis ○ MedImmune
37. Lot Number: 3b7788
38. Expiration date: 01/39/2999

39. Dose # ◉ 1 ○ 2
40. Dosage ○ 0.2 ml (LAIV only) ◉ 0.25 ml ○ 0.50 ml
41. Site ◉ RD ○ RT ○ LD ○ LT ○ Intranasal

42. Date Vaccine Administered (mm/dd/yyyy): / /
43. MVA # 81
44. PIN 3888
45. Screener Initials nlb
46. Signature of person administering the vaccine:
47. Name and Title of person who administered vaccine:

Note: please sign above

48. Location or Clinic Name:
Street Number:
Street Name:
City:
State:
Zip Code:

Print Form

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