

# Influenza A (H1N1) Public Provider Vaccination Administration Record

PRINT in capital letters as shown here

EXAMPLE 1 2 3

Mark boxes like this:



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



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										2. Last Name of person receiving vaccination																								
Home address of person receiving vaccine										3. Street Number										4. Street Name										5. Apt No.				
6. City/Town										7. State					8. Zip Code																			
9. Phone number where we can reach you or parent/guardian (if child)										10. DOB (mm/dd/yyyy)					11. Age (years)					12. Months <small>If person receiving vaccine is &lt;1 year old, please give age in months.</small>														

13. Race <input type="radio"/> White <input type="radio"/> Black or African American <input type="radio"/> Asian <input type="radio"/> Other (optional) <input type="radio"/> American Indian or Alaskan Native <input type="radio"/> Native Hawaiian or Pacific Islander										14. Hispanic or Latino? <input type="radio"/> Yes <input type="radio"/> No (optional)					15. Gender <input type="radio"/> Male <input type="radio"/> Female				
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**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?										<input type="radio"/> Yes <input type="radio"/> No				
17. Is the person receiving vaccine (adult or child) pregnant or think they might be pregnant?										<input type="radio"/> Yes <input type="radio"/> No				
18. Is the person receiving vaccine (adult or child) allergic to eggs, thimerosal or other vaccine components?										<input type="radio"/> Yes <input type="radio"/> No				
19. Has the person receiving vaccine (adult or child) ever had a serious reaction to any vaccine?										<input type="radio"/> Yes <input type="radio"/> 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?										<input type="radio"/> Yes <input type="radio"/> No				
21. Is the person receiving vaccine (adult or child) sick with a fever today?										<input type="radio"/> Yes <input type="radio"/> No				
22. Does the person receiving vaccine (adult or child) have any of the following medical conditions? <b>PUT AN 'X' IN EACH BOX THAT APPLIES, if none leave blank</b>														
<input type="checkbox"/> Asthma		<input type="checkbox"/> Cancer		<input type="checkbox"/> Heart Disease		<input type="checkbox"/> Kidney Disease		<input type="checkbox"/> Lung Disease						
<input type="checkbox"/> Blood Disorder		<input type="checkbox"/> Diabetes		<input type="checkbox"/> Immune Disorder		<input type="checkbox"/> Liver Disease		<input type="checkbox"/> Neurological Disease						

**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										28. Signature of person receiving vaccine or parent/guardian if a minor									
27. Last Name of Parent/Guardian if child										<b>Once you sign the consent, you may stop. The person giving you the vaccine will complete the rest of the form.</b>									

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

29. Insurance Information Needed? <input type="radio"/> Yes <input type="radio"/> No										30. Insurance Company										31. Insurance ID No.									
32. First and Last Name of Policy Holder (PLEASE PRINT)																													
33. Vaccine					34. VIS publication date					35. If vaccine label available, place in box to the right. If no label completed information below (#36 - 38).										place label here									
INFLUENZA A H1N1					1 0 / 0 2 / 2 0 0 9																								
36. Manufacturer <input type="radio"/> Sanofi Pasteur <input type="radio"/> GlaxoSmithKline <input type="radio"/> CSL Biotherapies <input type="radio"/> Novartis <input type="radio"/> MedImmune										37. Lot Number										38. Expiration date									
39. Dose # <input type="radio"/> 1 <input type="radio"/> 2					40. Dosage <input type="radio"/> 0.2 ml (LAIV only) <input type="radio"/> 0.25 ml <input type="radio"/> 0.50 ml					41. Site <input type="radio"/> RD <input type="radio"/> RT <input type="radio"/> LD <input type="radio"/> LT <input type="radio"/> Intranasal																			
42. Date Vaccine Administered (mm/dd/yyyy)										43. MVA #					44. PIN					45. Screener Initials					46. Signature of person administering the vaccine				
47. Name and Title of person who administered vaccine																													
48. Location or Clinic Name																													
Street Number										Street Name																			
City										State										Zip Code									

