Influenza A (H1N1) Public Provider Vaccination Administration Record *(Simplified)*

First Name PLEASE PRINT

School or clinic use only: Child needs second dose ☐ Yes ☐ No

Last Name

Gender: ☐ Male ☐ Female

Street Number | Street Name | Apt No.

City/Town | State | Zip Code

Phone number where you can be reached ( ) - | Date of Birth (mm/dd/yyyy) / / | Age (years) | If <1 yr old, give Age in Months

First Name of Parent/Guardian if child | Last Name of Parent/Guardian if child

School Name -- FOR SCHOOL-BASED CLINICS ONLY

Please Answer the Following Questions

Are you (or child) pregnant or think they might be pregnant?	☐ Yes	☐ No
Are you (or child) sick with a fever?	☐ Yes	☐ No
Have you (or child) ever had a serious reaction to a flu shot?	☐ Yes	☐ No
Are you (or child) allergic to eggs, gelatin, or thimersol (a preservative)?	☐ Yes	☐ No
Have you (or child) ever had Guillian-Barre Syndrome?	☐ Yes	☐ No
In the past year, have you (or child) have cancer, leukemia, HIV or AIDS or other immune system problem, or taken steroids or anticancer drugs, immune (gamma) globulin,or received blood transfusion or blood products or had radiation treatment?	☐ Yes	☐ No
Are you (or child) on long term aspirin therapy?	☐ Yes	☐ No
Have you (or child) taken antivirals within 48 hours prior to this visit or received a vaccine in the past 4 weeks?	☐ Yes	☐ No

Do you (or child) have any of the following medical conditions?

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

PLEASE READ THE FOLLOWING AND SIGN BELOW. PARENT/GUARDIAN please sign for minor child. I have received the Influenza A (H1N1) Monovalent Vaccine Information Statement dated 10/2/2009. 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.

SIGNATURE (person receiving vaccine or parent/guardian): _____

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

Date Vaccine Administered (mm/dd/yyyy) / / | MVA # 12 | PIN 1068 | Screener Init | Signature & Title of Vaccine Administrator:

Dose No ☐ 1 ☐ 2 | Site ☐ RD ☐ LD ☐ RT ☐ LT ☐ Intranasal | Dosage ☐ 0.25 ml ☐ 0.50 ml ☐ 0.2 ml (LAIV only)

Place Label here OR fill in boxes

Vaccine
☐ Sanofi Pasteur ☐ GlaxoSmithKline ☐ Medimmune ☐ Novartis ☐ CSL Biotherapies

Lot Number | Expiration date / /

Location or Clinic Name: STRATFORD HEALTH DEPARTMENT

Street Number: 468 | Street Name: BIRDSEYE STREET

City: STRATFORD | State: CT | Zip Code: 06651

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