*LHD name*_____
*LHD address*_____
*Off-site Location*_____

PEF label OR

DOCUMENT#: _____

HID/LOC/SITE: _____

# H1N1 Influenza Vaccine ADMINISTRATION RECORD

**NAME:** _____ **SOCIAL SECURITY#:** _____

**ADDRESS:** _____
STREET CITY COUNTY STATE ZIP

**BIRTHDATE:** _____/_____/_____ **PHONE NUMBER:** _____
MONTH DAY YEAR

**RACE:** (Check ONE or MORE) ☐ **(W)** White ☐ **(B)** Black or African American ☐ **(N)** American Indian or Alaska Native

☐ **(A)** Asian ☐ **(H)** Native Hawaiian or Other Pacific Islander **ETHNICITY:** Hispanic or Latino **(Y)** Yes or **(N)** No

**SEX:** (Check ONE) ☐ Male ☐ Female

DO YOU HAVE **MEDICAID** ? ☐ YES ☐ NO IF YES, **MEDICAID NUMBER**: _____

DO YOU HAVE **MEDICARE** ? ☐ YES ☐ NO IF YES, **MEDICARE NUMBER**: _____

DO YOU HAVE **HEALTH INSURANCE** ? ☐ YES ☐ NO

IF YES, **COMPANY NAME:** _____ **POLICY#:** _____

**SUBSCRIBER'S NAME:**_____**GROUP #:**_____

The health department may keep this record in a medical file. They will record what vaccine was given, when the vaccine was given, the name of the company that made the vaccine, the vaccine's special lot number, the vaccine injection site, the signature and title of the person who gave the vaccine, and the address where the vaccine was given.

**"I have read or have had explained to me the 2009-2010 Vaccine Information Statement (VIS) and understand the risks and benefits for the:** (Check one box)

**( ) 2009-2010** *Inactivated* ***H1N1 influenza vaccine, (VIS dated 10/2/09)***

**( ) 2009-2010** *Live,* ***Intranasal H1N1 influenza vaccine, (VIS dated 10/2/09***

☐ **ASSIGNMENT OF BENEFITS** I request that payment of authorized medical insurance benefits be made to the local health department listed above on behalf of name above, for services received. I also authorize the local health department to release medical information to Medicare, Other Third Payors (insurance carriers, Medicaid, etc.) and their agents to determine payment for services. **I will not be responsible for any charges for the H1N1 influenza vaccine or administration.**

**X**_____ **DATE:** _____

**Signature of person to receive vaccine or person authorized to make the request (parent or legal guardian)**

## FOR HEALTH DEPARTMENT USE ONLY

Vaccine Manufacturer:_____Vaccine Lot Number:_____

Injection Site:_____

Signature and Title of Provider: _____ Provider# :_____

NOTES: _____

| | ADMINISTRATION OF H1N1 Influenza Vaccine |
|---|---|
| | *(Circle one)* G9141 **or** 90470 Administration of Influenza Vaccine **ICD Code:** V0481 Need for prophylactic vaccination |
| | _____ Dose 1 _____ Dose 2 |