*LHD name*_____
*LHD address*_____
*Offsite Location*_____

PEF label OR

DOCUMENT#: _____

HID/LOC/SITE: _____

SCHOOL FORM

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 #:**

Y N

□ □ Has your child had a previous H1N1 vaccine? ____ Nasal ____ Shot DATE:_____
□ □ Does your child have a serious allergy to eggs?
□ □ Does your child have any other serious allergies? Please list_____
□ □ Has your child ever had a serious reaction to a previous dose of flu vaccine?
□ □ Has your child ever had Guillain-Barre Syndrome (a temporary severe muscle weakness) within 6 weeks after receiving a flu shot?
□ □ Has your child been vaccinated with any vaccine (not just flu) within the past 30 days? Vaccine_____ Date_____
□ □ Does your child have any of the following: asthma, diabetes, disease of the lungs, heart, kidneys, liver, nerves, or blood?
□ □ Is your child on long-term aspirin or aspirin containing therapy (does your child take aspirin every day)?
□ □ Does your child have a weak immune system (HIV, cancer, or medications such as steroids or those used to treat cancer)?
□ □ Is your child pregnant?
□ □ Does your child have close contact with a person who needs care in a protected environment (example, someone who has recently had a bone marrow transplant)?

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)

I **DO NOT GIVE CONSENT** to the Local Health Department and its staff for my child named at the top of this form to be vaccinated with this vaccine.
_____ **DATE**:_____
Signature of 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