



H1N1 Vaccine Administration Record

**PLEASE PRINT**

Last:		First:	
Address:		City:	
Zip:	Phone:	Gender: M F	Birthdate: Age:

**I understand and agree that my information will be entered into a State registry to track H1N1 vaccine usage. I have received a copy of the Health District's Notice of Privacy Practices (HIPPA).**

\_\_\_\_\_  
Signature of person authorized to make the request

\_\_\_\_\_  
Date

	YES	NO
1) Does the recipient have a moderate or severe allergy to eggs or thimerosal (mercury)?	_____	_____
2) Has the recipient had a serious reaction (trouble breathing, prolonged rash, wheezing, etc.) to previous dose of flu vaccine? .....	_____	_____
3) Has the recipient had Guillain Barre Syndrome (temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine? .....	_____	_____

Our office may keep this record on file. We will record what vaccine was given, when the vaccine was given, the company that produced the vaccine, the lot number, and a signature with the title of the person who administered the vaccine.

"I, the authorized requestor, have read or had explained to me the information from the Vaccine Information Statement (VIS) about H1N1 vaccine. I understand the benefits and risks of my child receiving an H1N1 vaccine as stated on the 2009 H1N1 Influenza VIS. I ask that the vaccine be given to the person named above for whom I am authorized to make this request."

**AREA BELOW FOR OFFICE USE ONLY**

<i>Date vaccine administered:</i>	<i>Vaccine manufacturer:</i>
<i>Vaccine lot number:</i>	<i>Injection Site: RD LD RT LT</i> <i>Intranasal: _____</i>
<input type="checkbox"/> <i>Initial Dose</i>	<input type="checkbox"/> <i>Booster</i>

*Signature of Vaccine Administrator:* \_\_\_\_\_



The following questions will determine the eligibility for Flu Mist

Is the recipient:	YES	NO
Under 2 years of age?	_____	_____
Over 50 years of age?	_____	_____
Pregnant?	_____	_____
Allergic to MSG?	_____	_____
Allergic to Gentamicin?	_____	_____
Does the recipient have any of the following:		
Weakened immune system	_____	_____
Long term health problem	_____	_____
Heart disease	_____	_____
Lung disease	_____	_____
Asthma	_____	_____
Kidney or liver disease	_____	_____
Metabolic disease such as diabetes	_____	_____
Anemia or other blood disorder	_____	_____
Muscle or nerve disorder that leads to breathing or swallowing problems	_____	_____
Does the recipient care for someone who requires care in a protected environment, such as a bone marrow transplant unit?	_____	_____
Has the recipient received a live vaccine within the last 30 days?	_____	_____