

2009-2010 H1N1 INFLUENZA VACCINE

Cabell-Huntington Health Department

703 7th Avenue

Huntington, WV 25701

(304)523-6483

ONLINE VERSION

Personal Information (Please Print Clearly): Date _____

Name: _____

Birth Date: _____ Age: _____ Sex: _____ Telephone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Have you ever had a Serious reaction to the influenza vaccine? Yes No

Have you ever had a Serious allergic reaction to eggs? Yes No

Have you ever had Guillain-Barre syndrome? Yes No

Have you had an anti-viral within the last 48 hours? Yes No

I have been given a copy and have read or have had explained to me the information sheet about H1N1 Influenza Virus Vaccine 2009-2010 dated 10/02/09 or Live, Intranasal H1N1 Influenza Vaccine dated 10/02/09. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and request that this be given to me or to the person named above for whom I am authorized to make this request. I acknowledge that I have been offered a copy of the *Notice of Privacy Practices* for the Cabell-Huntington Health Department. This notice explains how my protected health information is used and/or disclosed for the purposes of treatment, payment, and health care operations.

Signature: _____

Area Below is for Staff Use Only:

Priority Group (must be in one of these groups to qualify)

- Pregnant
- Household contact or a caregiver of a child under 6 months of age
- Health Care Worker
- 6 months to 24 years of age
- Between 25 and 64 and have a chronic health condition
- Between 25 and 64 years of age without chronic health conditions
- Over 64 years of age

Screening (If checked must have injectable)

- Younger than 2 years of age or older than 49 years of age
- Had an MMR, Varicella, Zostavax, or Seasonal Flu Mist in last 4 weeks.
- Chronic heart or lung disease, asthma, diabetes, kidney disease, anemia, neurologic/neuromuscular, immunosuppression caused by HIV or medication, cancer, leukemia or other blood disorders (not including high blood pressure).
- Pregnant or nursing

No Contraindications were identified

H1N1 Influenza vaccine administered.
Manufacturer _____ Lot # _____ Exp. _____
Location _____

H1N1 Flu-Mist vaccine administered.
Manufacturer _____ Lot # _____ Exp. _____
Location _____

Adm. by Signature _____

_____ 2ND Dose Needed