

# 2009 Novel H1N1 Influenza Form 2009-2010

PLEASE PRINT CLEARLY WITH BLOCK LETTERS  
USING A BLUE OR BLACK MEDIUM POINT INK PEN

A B C      1 2 3

MALE      FEMALE  
     

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
Initial      First Name

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date Of Birth

\_\_\_\_\_  
Street Address 1

\_\_\_\_\_  
Apt #

\_\_\_\_\_  
Street Address 2 (if needed)

\_\_\_\_\_  
County

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

Mark one:

Medicare       Medicaid       Other Insurance

\_\_\_\_\_  
Specify if Other Insurance

\_\_\_\_\_  
Insurance Number

\_\_\_\_\_  
Group Number

The following questions will help us know if the above named person can get the 2009 H1N1 Influenza vaccine. Please mark YES or NO for each question. Has the person named above:

	YES	NO
1. ever had a serious allergic reaction to eggs?	<input type="checkbox"/>	<input type="checkbox"/>
2. ever had any other serious allergic reactions that you know of? Please list:	<input type="checkbox"/>	<input type="checkbox"/>
3. ever had a serious reaction to a previous dose of flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
4. ever had Guillain-Barre' Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>

I give permission for myself or the above named child to receive vaccine for the 2009 novel H1N1 virus. I understand/authorize the following:

- All medical records are strictly confidential. Medical records may be used for audit and statistical purposes.
- The vaccine itself is provided free. An administration fee may be billed to my insurance (for example, private insurance, Medicaid, or Medicare) using my protected health information.
- If I do not have insurance, I may be personally charged the administration fee but if I cannot afford it, the fee will not be charged or I will be referred to a clinic that does not charge.
- NOTE: vaccine clinics at public schools and health departments will not charge the administration fee.
- I have been offered a copy of the provider's Notice of Privacy Practices.
- I have read and understand the Vaccine Information Statement and have had the opportunity to discuss it with the provider.

\_\_\_\_\_  
Authorization Signature      \_\_\_\_\_  
Date

**OFFICE USE ONLY**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date Vaccine and VIS Given

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date of VIS

\_\_\_\_\_  
Clinic Site (Assigned Number)

LA	RA	LT	RT	IM	NASAL	1	2
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Site of Injection				Route		Dose	

\_\_\_\_\_  
Manufacturer and Lot Number

\_\_\_\_\_  
Print or Stamp Site Name

\_\_\_\_\_  
Signature of Provider/Vaccinator