

Coles County Health Department

2009 Influenza A (H1N1) Monovalent Influenza

Vaccine Administration Record

I have read or had explained to me the information about H1N1 influenza and H1N1 influenza vaccine. I have had a chance to have questions answered to my satisfaction. I understand the benefits and risks of influenza vaccine and request the vaccine be administered to me or the person named below for whom I am legally authorized to make this request.

PLEASE PRINT

Last Name:	First Name:	Middle Initial:
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Street Address:	City:
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State:	Zip Code:	Phone #:	Birthdate:	Age:
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Do any of the following apply to person being vaccinated? Please check all that apply.

- | | | |
|---------------------------------------------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------------------|
| <input type="checkbox"/> I am feeling well. | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Long-term aspirin treatment |
| <input type="checkbox"/> Pregnant | <input type="checkbox"/> Lung disease | <input type="checkbox"/> History of Guillain-Barré Syndrome |
| <input type="checkbox"/> Chronic medical condition | <input type="checkbox"/> Asthma | |
| <input type="checkbox"/> Allergy to eggs or any other vaccine component | <input type="checkbox"/> Kidney disease | |
| <input type="checkbox"/> Child 8 years or younger who has never received flu vaccine before | <input type="checkbox"/> Diabetes / Metabolic Disease | |
| | <input type="checkbox"/> Anemia, other blood disorders | |
| | <input type="checkbox"/> Weakened immune system | |

I do hereby consent to allow the health department and its designated employees to enroll and provide services through the programs offered by the department. I understand the nature and consequences of any procedures to be performed will be explained to me. I understand the health department is already authorized to use the information gained during treatment to bill me, or any other potential sources of reimbursement, such as government programs in which I am enrolled or qualify for services. I acknowledge that I have had an opportunity to receive a copy of the "Joint Notice of Privacy Practices" dated 4/14/2003 as well as the 2009 H1N1 Vaccine Information Statement (VIS) from the Health Department.

Signature:	Date:
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For Clinic Use Only

Date: _____ Clinic Location: _____

Vaccine: **Inactivated Influenza A (H1N1) Monovalent Vaccine** Lot # **UP001AA**
 Sanofi Pasteur

Intranasal Influenza A (H1N1) Monovalent Vaccine Lot # **500763P**

Site:
 Intranasal R & L nostril RN/LPN/Student Nurse: _____
 Deltoid R or L
 Vastus Lateralis R or L