Vaccine Administration Record-Age 2-49 Years
2009 H1N1 Monovalent Live Attenuated Influenza Vaccine

Please complete and sign this form. If you do not fill it out completely, you may be denied immunization services. The form may be kept in your (or your child's) medical file. This information is private and will not be shared with anyone except healthcare agencies, childcare facilities, and schools to help them provide immunization services, make sure immunization requirements have been met, and prevent disease by monitoring immunization needs. These agencies may include the Minnesota Department of Health; licensed healthcare professionals such as doctors and nurses; health insurers; Head Start programs; county public health agencies; community action agencies; and licensed healthcare facilities such as hospitals.

Information About Person to Receive Vaccine (please print)

Name:	Last	First	Middle Initial		
Address:	Street	City	County	State	Zip
Birthdate	Age				

Vaccine to be given:

2009 H1N1 Monovalent Live Attenuated Influenza (LAIV)
0.1ml into each nostril

I have read or have had explained to me the fact sheet(s) called "What You Need to Know," also known as "vaccine information statements," about the vaccine(s) and disease(s) indicated above. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks and ask that the vaccine(s) be given to me or the person named above.

Signature of person to receive vaccine or authorized representative or legal guardian:

X _____ Date: _____

For Clinic/Office Use

Clinic/office address: CARVER COUNTY PUBLIC HEALTH

Vaccine type : 2009 H1N1 Monovalent Live Attenuated Influenza (LAIV) Intranasal
Manufacturer: Medimmune
Lot number:
Route: Intranasal

Date on VIS: 10/2/09
Date VIS given:

*Signature and title of person(s) administering vaccine

Note to providers: Federal and Minnesota state law do **not** require signatures acknowledging receipt of vaccine information statements (VISs). However, to conform with your own agency policies, you may wish to use this form during clinics to record the signature of the vaccinee or authorized representative as well as NCVIA requirements.

MINNESOTA MDH DEPARTMENT OF HEALTH
Immunization Program
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-5503 or 1-800-657-3970
www.health.state.mn.us/immunize

Carver County Public Health
Government Center Administration Building
600 East Fourth Street, Chaska, MN 55318
Phone: 952-361-1329 Fax: 952-361-1360
Email: public-health@co.carver.mn.us

CCPH Revised: 10-23-09

IC#140-0510
12/06

Screening Questionnaire for Intranasal Influenza Vaccination

For adult patients as well as parents of children to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child intranasal influenza vaccine (FluMist) today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1. Is the person to be vaccinated sick today?	☐	☐	☐
2. Does the person to be vaccinated have an allergy to eggs or to a component of the influenza vaccine?	☐	☐	☐
3. Has the person to be vaccinated ever had a serious reaction to intranasal influenza vaccine (FluMist) in the past?	☐	☐	☐
4. Is the person to be vaccinated younger than age 2 years or older than age 49 years?	☐	☐	☐
5. Does the person to be vaccinated have a long-term health problem with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., diabetes), or anemia or another blood disorder?	☐	☐	☐
6. If the person to be vaccinated is a child age 2 through 4 years, in the past 12 months, has a healthcare provider ever told you that he or she had wheezing or asthma?	☐	☐	☐
7. Does the person to be vaccinated have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as high-dose steroids, or cancer treatment with radiation or drugs?	☐	☐	☐
8. Is the child or teen to be vaccinated receiving aspirin therapy or aspirin-containing therapy?	☐	☐	☐
9. Is the person to be vaccinated pregnant or could she become pregnant within the next month?	☐	☐	☐
10. Has the person to be vaccinated ever had Guillain-Barré syndrome?	☐	☐	☐
11. Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in a protective isolation (such as in a hospital room with reverse air flow)?	☐	☐	☐
12. Has the person to be vaccinated received any other vaccinations in the past 4 weeks?	☐	☐	☐

Form reviewed by: _____ Date: _____

Technical content reviewed by the Centers for Disease Control and Prevention, September 2009.

www.immunize.org/catg.d/p4067.pdf • Item #P4067 (9/09)