2009-2010 H1N1 INFLUENZA VACCINATION CONSENT AND ADMINISTRATION RECORD

Patient - Please Complete Sections 1 Through 8, Sign and Date
(Print clearly in capital letters using blue or black ink and neatly color in circles)

NOT FOR USE SAMPLE

1. LAST Name:

First Name: **Middle Initial:**

Address:

City: **State:** **Zip:**

Date of Birth: MM / DD / YYYY **Gender:** ○ M ○ F **County Code (*See Back*):**

Phone Number: - -

2. Ethnicity: Hispanic or Latino: ○ Yes ○ No

3. Race (*Color in all that apply*): ○ American Indian/Alaskan Native ○ Asian ○ Black/African-American ○ Native Hawaiian/Pacific Islander ○ White ○ Unknown ○ Other (Specify) ______

4. Which dose of the H1N1 Vaccine are you receiving? ○ Dose 1 ○ Dose 2 ○ Don't know

5. Are you pregnant? ○ Yes ○ No ○ Unknown

6. Do you live with or care for children younger than 6 months old? ○ Yes ○ No

7. Are you a health care or emergency medical service worker with direct patient contact? ○ Yes ○ No

8. Do you have an underlying risk factor such as asthma or other chronic health condition or a compromised immune system? ○ Yes ○ No

CONSENT AND REQUEST TO RECEIVE H1N1 VACCINATION. I have read the information above and confirm that it is correct. I have been given a copy and have read, or I have had explained to me, the information in the "Vaccine Information Sheet" for the H1N1 vaccine. I have had the chance to ask questions and they were answered to my approval. I understand the benefits and risks of the H1N1 vaccine and I have given my permission to have this vaccine given to me or the person for whom I have the power to make this request. I have been given, or have been offered, a copy of the Notice of Privacy Practices.

Signature of the person receiving and/or consenting to the vaccination:

______________________ ______________________ Date: ______________

Relation to person receiving the vaccination

For Clinic Use Only

Client Screened for Contraindications: Screener's Initials ______

Client given VIS on ______ and understands VIS dated ______

Manufacturer: ○ CSL ○ Medimmune ○ Sanofi Pasteur ○ GSK ○ Novartis Lot #:

Dosage (If applicable): ○ 0.25mL (6-35 months) ○ 0.50mL (3 years and older) ○ Other ______

Route of Administration: ○ Intranasal IM Injection: ○ LA ○ RA ○ LL ○ RL ○ Other ______

Clinic Site: Provider #:

Place Stamp Here

Date: MM / DD / YYYY

Signature of Vaccinator: ______________________

MDH1N1 09/09

DHMH ORIGINAL