

# Influenza A (H1N1) Public Provider Vaccination Administration Record *(Simplified)*

First Name PLEASE PRINT

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School or clinic use only:  
Child needs second dose  Yes  No

Last Name

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Gender:  Male  Female

Street Number

Street Name

Apt No.

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City/Town

State

Zip Code

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Phone number where you can be reached

Date of Birth (mm/dd/yyyy)

Age (years)

If <1 yr old,  
give Age in  
Months

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First Name of Parent/Guardian if child

Last Name of Parent/Guardian if child

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School Name -- FOR SCHOOL-BASED CLINICS ONLY

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**Please Answer the Following Questions**

Are you (or child) pregnant or think they might be pregnant?  Yes  No

Are you (or child) sick with a fever?  Yes  No

Have you (or child) ever had a serious reaction to a flu shot?  Yes  No

Are you (or child) allergic to eggs, gelatin, or thimersol (a preservative)?  Yes  No

Have you (or child) ever had Guillian-Barre Syndrome?  Yes  No

In the past year, have you (or child) have cancer, leukemia, HIV or AIDS or other immune system problem, or taken steroids or anticancer drugs, immune (gamma) globulin, or received blood transfusion or blood products or had radiation treatment?  Yes  No

Are you (or child) on long term aspirin therapy?  Yes  No

Have you (or child) taken antivirals within 48 hours prior to this visit or received a vaccine in the past 4 weeks?  Yes  No

Do you (or child) have any of the following medical conditions?

- |   |                                   |  |   |   |
|---|-----------------------------------|--|---|---|
| <input type="checkbox"/> Asthma         | <input type="checkbox"/> Cancer   | <input type="checkbox"/> Heart Disease   | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Lung Disease         |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Immune Disorder | <input type="checkbox"/> Liver Disease  | <input type="checkbox"/> Neurological Disease |

PLEASE READ THE FOLLOWING AND SIGN BELOW. PARENT/GUARDIAN please sign for minor child. I have received the Influenza A (H1N1) Monovalent Vaccine Information Statement dated 10/2/2009. I have had a chance to ask questions and I understand the benefits and risks of the vaccine. I request that the vaccination be given to me or to the person for whom I am authorized to make this request.

SIGNATURE (person receiving vaccine or parent/guardian): \_\_\_\_\_

**STOP! DO NOT WRITE BELOW THIS LINE (vaccine administrator completes this section)**

Date Vaccine Administered (mm/dd/yyyy)

MVA #

PIN

Screener Init

Signature & Title of Vaccine Administrator:

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Dose No

Site

Dosage

<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> RD	<input type="checkbox"/> LD	<input type="checkbox"/> RT	<input type="checkbox"/> LT	<input type="checkbox"/> Intranasal	<input type="checkbox"/> 0.25 ml	<input type="checkbox"/> 0.50 ml	<input type="checkbox"/> 0.2 ml (LAIV only)
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*Place Label here OR fill in boxes*

Vaccine

Sanofi Pasteur  GlaxoSmithKline

Lot Number

Expiration date

Medimmune  Novartis  CSL Biotherapies

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Location or Clinic Name

W	E	S	T	P	O	R	T		W	E	S	T	O	N		H	E	A	L	T		D	I	S	T	R	I	C	T						
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Street Number

Street Name

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City

State

Zip Code

W	E	S	T	P	O	R	T																														
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