

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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C T

Phone number where you can be reached

Date of Birth (mm/yy/ddd)

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

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Please Answer the Following Questions

Are you (or child) pregnant or think they might be pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you (or child) sick with a fever?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you (or child) ever had a serious reaction to a flu shot?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you (or child) allergic to eggs, gelatin, or thimersol (a preservative)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you (or child) ever had Guillian-Barre Syndrome?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you (or child) on long term aspirin therapy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you (or child) taken antivirals within 48 hours prior to this visit or received a vaccine in the past 4 weeks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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	Dosage	Site
<input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> 0.25 ml <input type="checkbox"/> 0.50 ml <input type="checkbox"/> 0.2 ml (LAIV only)	<input type="checkbox"/> RD <input type="checkbox"/> LD <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Intranasal

<p style="font-style: italic; border: 1px solid gray; padding: 2px;">Place Label here OR fill in boxes</p> <p>Vaccine Manufacturer</p> <input type="checkbox"/> Sanofi Pasteur <input type="checkbox"/> GlaxoSmithKline <input type="checkbox"/> CSL Biotherapies <input type="checkbox"/> Medimmune <input type="checkbox"/> Novartis	<p>Lot Number</p> <table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td> </tr> </table> <p>Expiration date</p> <table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td> </tr> </table>																																								

Location or Clinic Name

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Street Number Street Name

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City State Zip Code

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