

H1N1 INFLUENZA VACCINE (TIV) CONSENT & ADMINISTRATION RECORD

PLEASE PRINT INFORMATION ABOUT PERSON TO RECEIVE VACCINE

Last Name			First Name			Middle Initial			
Street Address			Apt #		City		State	Zip	
Month	Birth Date		Age	Sex		County			
	Day	Year		<input type="checkbox"/> Male	<input type="checkbox"/> Female	Home Phone			

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Have you ever had a serious reaction to eggs, chicken products, latex, thimerosal? Yes No
2. Have you had the flu shot before? Yes No
3. Have you ever had a serious reaction to the flu shot? Yes No
4. Have you ever had Guillain Barré syndrome? Yes No
5. Have you been ill or had a fever within the last 48 hours? Yes No

CONSENT FOR VACCINATION

I GIVE CONSENT to the STATE/LOCAL health department and its staff to vaccinate me with this vaccine. I have received the 2009-2010 Vaccine Information Statement for the 2009 H1N1Influenza vaccine and understand the risks and benefits. I understand that the information is confidential and will only be shared with organizations or persons who are authorized by law to receive it. This includes the Minnesota Department of Health, a health care provider or health care organization providing services on behalf of myself, and anyone else authorized under law to receive it. This information will be included in the Minnesota Immunizations Information Connection registry, a secure web-based registry system for health care providers. If you choose not to have this information shared with the registry please call 1-800-657-3970.

X _____
Signature of person to receive vaccine or person authorized to make the request (parent or guardian)

Date

NURSE USE ONLY

Vaccine Manufacturer and Vaccine Lot: _____

Date Vaccine Administered: _____ 2009 Site of Injection: **Deltoid** L R Other _____

Pediatric dose (6-35 mos) 0.25 ml. _____

Date of VIS 10/02/2009 Signature of Vaccine Administrator: _____

Check if Applicable: BCPH Employee _____

Accounting Staff Only: Stats Done _____ Entered in MIIC _____

FOR OFFICE USE ONLY

H1N1 VACCINE SUB-PRIORITY GROUPS

- _____ Pregnant Woman
- _____ Health Care Worker, EMS
- _____ Healthy Child 6 months through 35 months
- _____ Healthy Child 3 years through 18 years
- _____ Person 6 months through 18 years with underlying health conditions
- _____ Household contact or caregiver of infant under 6 months

H1N1 PRIORITY GROUPS

- _____ Healthy person 6 months through 24 years of age
- _____ Person 25 yrs through 64 yrs with underlying health conditions

GENERAL POPULATION

- _____ 25 years and older