H1N1 (SWINE) FLU VACCINE ADMINISTRATION RECORD

LIVE (H1N1 FLUMIST)

Risk Factor: _____

H1N1(SWINE) INFLUENZA MIST Manufactured by: MEDIMMUNE ☐ Lot: 500763P Expiration date 1/ 25/2010 Vaccine Administered: Site of Injection: NASAL MIST	☐

FOR OFFICE/CLINIC USE ONLY

Clinic/Office Address _Macon County Health Department_ 1221 E. Condit _Decatur, Il

Signature of Vaccine Administrator_______________________________________

Title of Vaccine Administrator_________Registered Nurse/LPN______________________

INFORMATION ABOUT PERSON TO RECEIVE VACCINE

Please Print

Last name	First	Middle Initial	Birthdate	Age
Street Address	**City**	**Zip Code**	**County**	**Telephone #**
Male______	Female_______			

I have read or have had explained to me the information in the Vaccine Information Sheet about the H1N1 LIVE Influenza Vaccine (10/02/2009). I have had a chance to ask questions and these have been answered to my satisfaction. I believe I understand the benefits and risks of the H1N1 LIVE Influenza Vaccine and ask that the selected vaccine/vaccines be given to me or the persons named above for who I am authorized to make this request. I accept responsibility for seeking medical attention for any problems with this vaccination. I authorize billing of this/these vaccination to Medicare/Medicaid. I give permission for the Macon County Health Department to release the date of this vaccine to my physician or any other health care provider needing this information.
Signature of person to receive the influenza vaccine, or the person authorized to make request.
I do hereby consent to allow the Macon County Health Department to provide the immunizations requested.

X____ Date________________

Medicaid	Medicare	Cash	Check #_______	NO
☐	☐	☐	☐	☐

Medicaid or Medicare #_______________________________________

IMMUNIZATION CONTRAINDICATION CHECKLIST

We request that any persons receiving **any vaccines** should stay in the seating area for 15 minutes after receiving the vaccine.

1. Has the client ever had an influenza vaccination? Y N
2. Does the client have any long term health problem such as asthma, COPD, heart disease, kidney disease, metabolic disease (e. g. diabetes) anemia or other blood disorder? If the client to be vaccinated is between the ages of 2 and 4 years, has a healthcare provider told you that the child had wheezing or asthma in the past? Y N
   If yes, the client needs the inactivated shot not the mist.
3. Does the client have any cancer, leukemia, AIDS or any other immune system problem? Does the client take cortisone, prednisone, steroids or anticancer drugs or has client had radiation treatments? Y N
   If yes, the client needs the inactivated shot not the mist.
4. Is person receiving the vaccine ill today? (something more serious than a cold, such a fever over 100 degrees) Y N
5. Has the person receiving the vaccine ever had a reaction to a previous immunization such as fever greater than 105 degrees, convulsions, total collapse or shock, severe itching rash or anaphylactic allergic reaction? Y N
6. Is the person receiving the vaccine allergic to any components of the vaccine? (chicken, eggs, chicken feathers, chicken dander or thimerosal containing products like eye contact lens solution or mercury containing products) Y N
7. Has the client ever had Guillain-Barre Syndrome? Y N
   If yes, the client should receive vaccine from their physician.
8. Has the client ever had any seizures, brain or other nervous system problems? Y N
9. For Women: Are you pregnant or is there a chance you could become pregnant during the next month? If yes, the client needs the inactivated shot not the mist. Y N
10. Have you received any vaccinations in the past 4 weeks? Y N

I also hereby acknowledge that I received a copy of the "Notice of Privacy Practices" from the Macon County Health Department dated April 14, 2003 and revised 3/16/2009.

Signature of person receiving vaccine__________________________________ Date_________
Or legal representative

Nurse or person reviewing the form __________________________________ Date_________