

H1N1 IMMUNIZATION CLINIC INFORMATION

Client Name: _____ Birth Date: _____

Male: ___ Female: ___ Mother's/Client Maiden Name: _____

If patient is a minor, Parent/Guardian Name: _____

Address: _____ City: _____

County: _____ State: _____ Zip: _____

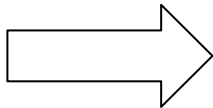
Phone: _____ Family Physician: _____

School (if applicable): _____

I wish to be present at my child's immunization.

This H1N1 Vaccination will be provided free of charge regardless of insurance coverage.

Medicare, Medicaid and private insurance companies will pay the vaccination administration fees. CMDHD will be billing insurance for the administration fee if there is insurance coverage.



Do you have health insurance that covers immunizations?

If yes, please provide the following information:

Medicaid/Medicare Number: _____

Other Insurance Number (if applicable): _____

Insurance Company Name: _____

Policy Number/Group #: _____

Contract Number/ID #: _____

Policyholder Name: _____

Policyholder Date of Birth: _____

Employers Name: _____

For office use only:

Vaccine	Date Dose Administered and VIS Given	Route	Site	Vaccine Manufacturer	Lot Number	Date of VIS	Name and Title of Vaccine Administrator

Client Name: _____
 (please print) *Last* *First* *Middle Initial*

Date of Birth: _____

⇒ **WAIT TO FILL OUT QUESTIONS AT THE TIME OF THE IMMUNIZATION CLINIC**
If parent/legal guardian will not be at immunization clinic, this form must be filled out no sooner than 48 hours or less before the clinic and sent with client to clinic.

If any of the following health screening questions are not clear, leave it blank and a healthcare worker will explain it to you.

Check each box YES or NO	YES	NO
1. Is the client sick today? (Please do not send you child for immunizations if they are sick.)		
2. Does the client have a serious allergy to eggs?		
3. Does the client have any other serious allergies to medications, food, latex, or any vaccines?		
4. Has the client ever had a serious reaction to a previous dose of flu vaccine?		
5. Has the client ever had Gullian-Barre syndrome (type of temporary severe muscle weakness) within 6 weeks of receiving flu vaccine?		
6. In the past 4 weeks has the client received any vaccinations?		
7. Does client have any of the following: recurrent wheezing, asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidney, liver, nerves, or blood?		
8. Is client on long-term aspirin or aspirin-containing therapy (example: daily dose of aspirin)?		
9. Does the client have a weakened immune system (examples: from cancer, leukemia, AIDS, or on medications for steroids or cancer)?		
10. Is female client pregnant?		
11. Does client have close contact with a person who needs a care in a protected environment (example: someone who has recently received a bone marrow transplant)?		
12. Has client taken any influenza antiviral medications in the last week (example: Tamiflu, Relenza)?		

My signature below proves:

- I have read or had explained to me the Vaccine Information Statement for the seasonal / H1N1 Influenza vaccine and understand the risks and benefits.
- I consent to the administration of the seasonal / H1N1 vaccine to me or to the person for whom I am authorized to make this request.
- I verify that all of the above information I supplied is correct to the best of my knowledge.
- I have received the HIPPA privacy notice.
- I consent that the administration of the vaccine be recorded by CMDHD and in the MCIR.

Signature of Client or Representative **Relationship to Client (if representative)**

Printed Name (if representative) **Date Signed** / /

For Office Use Only (do not write below this line)

Healthcare provider comments:

Refusal to Consent to Vaccination

I have received the H1N1 vaccination information and understand the purpose, risks and benefits, and possible consequences of not receiving seasonal / H1N1 vaccination. I understand that I may change my mind later, accept full responsibility for any consequences of not being vaccinated, and acknowledge that I have read and understand this statement.

Signature of Client or Representative **Date Signed** / / **Signature of Healthcare Worker** **Date Signed** / /