VACCINE ADMINISTRATION RECORD 2009-2010 H1N1 FLU PROGRAM

PLEASE PRINT:

NAME:______________________________ Phone # (___) ______________

Last First M.I.

☐ Male ☐ Female Date of Birth ______________ Age ________

Street Address: ____

Apt # City State Zip Code

Screening for H1N1 Flu: (to be completed by client or parent)
☐ Previously immunized for H1N1 flu
☐ Ever had a serious allergic reaction to eggs
☐ Previous serious reaction to any influenza vaccine
☐ History of Guillian-Barre syndrome
☐ Running a fever
☐ On aspirin therapy
☐ Autoimmune Disease

H1N1 Dose Today **(please circle one)**	
1	**2**

Your signature indicates that the above information is accurate and complete; authorizes Southern Nevada Health District to administer the H1N1 flu vaccine to patient named above and also indicates that you have received current written information regarding the vaccine to be given.

SIGNATURE: ______________________________ **DATE:** ____________

PARENT OR LEGAL GUARDIAN SIGNATURE REQUIRED FOR MINOR CHILD:

______________________________ **DATE:** ____________

(PARENT/GUARDIAN SIGNATURE)

ALL AREAS BELOW FOR SNHD STAFF ONLY

Medical Screener: Please select one option per patient **Screener Initials:**

- ☐ **Pregnant Women**
- ☐ **Household contacts/caregivers for children younger than six (6) months of age**
- ☐ **Healthcare and emergency medical services personnel**
- ☐ **Persons between the ages of six (6) months through 24 years**
- ☐ **People from ages 25-64 years who have chronic medical conditions associated with higher risk of medical complications from influenza**
- ☐ **General population**

VACCINE	DATE GIVEN	MFG / LOT #	VIS DATE	SITE	ROUTE	GIVEN BY:	TITLE
H1N1				LA LT RA RT	IM		LPN RN
H1N1 FLU MIST				IN	IN		LPN RN

SNHD Locations: ☐ SNHD MAIN ☐ SNHD HEND ☐ SNHD ELV ☐ SNHD NLV ☐ SNHD Mesquite

Other Clinic/Campaign Location: ______________________________

Record # ______________

Data Entry By: ______________________

APP: B.S. 9/25/09 leer\word\imm\var for H1N1 Flu English 2009-2010