



INFLUENZA VACCINE RECORD

2009 H1N1 INFLUENZA A

Information About Person To Receive Vaccine (Please Print)

_____	_____	_____	_____
Last Name		First Name	Middle Name
_____			_____
Mailing Address			Apt/Suite
_____	_____	_____	_____
City	State	ZIP	County
_____	_____	_____	_____
Date of Birth	Area Code	Phone Number	Parent/Guardian Name

PRIORITY CATEGORY CHECK ONE

- PREGNANT- TRIMESTER FIRST SECOND THIRD
- LIVE WITH OR CARE FOR INFANTS LESS THAN 6 MONTHS OLD
- HEALTH CARE OR EMERGENCY MEDICAL PERSONNEL
- ANYONE FROM 6 MONTHS THROUGH 24 YEARS OF AGE
- ANYONE FROM 25 THROUGH 64 YEARS OF AGE WITH CHRONIC MEDICAL CONDITION
(ASTHMA, DIABETES, HEART, RESPIRATORY, OR KIDNEY DISEASE)

CHECK THE BOX IF YOU HAVE ANY OF THESE:

- ALLERGY TO EGG?
- ASTHMA
- ALLERGY TO THIMERASOL?
- HISTORY OF GUILLAIN BARRE SYNDROME?
- FEVER?
- SEVERE REACTION TO A PREVIOUS FLU SHOT?

AGE:

I have read and I understand the information given to me including the Vaccine Information Statement. I have had a chance to ask questions and have them answered to my satisfaction. I believe I understand the benefits and risks of taking the vaccine and I request it be given to me or the person for whom I am authorized to sign. I hereby release the hospital and its agents from any and all liability associated with administration and potential side effects of the vaccine.

Signature _____

Date _____

Check Route/ Site/ Dose :

IM R deltoid L deltoid R thigh L thigh Nasal
 Dose 0.5ml 0.25ml

Manufacturer Check one :

- Novartis Lot 1007396P exp 1-2010
- Novartis Lot 10073804 exp 1/2010
- Sanofi (ped) Lot UT030EA exp 4/10/2011
- MEDIMMUNE LOT 5000783P EXP 2/12/2010

Signature of Vaccine Administrator

Signature Date

Date of VIS 10/2/2009