



State of New Hampshire 2009-2010 H1N1 Influenza Vaccine Registration and Consent VACCINE ADMINISTRATION RECORD



Information about person who will receive vaccine (please print)

LAST NAME		FIRST NAME		MI
ADDRESS		CITY	STATE	ZIP
HOME PHONE	OTHER PHONE	DATE OF BIRTH		AGE
()	()	/ /		

ANSWER QUESTIONS ON OTHER SIDE OF FORM →

- I have been given a copy and have read or have had explained to me the information in the Vaccine Information Statement for H1N1 Influenza vaccine.
- I have had a chance to ask questions which were answered to my satisfaction.
- I believe I understand the benefits and risks of the H1N1 influenza vaccine and request that the H1N1 influenza vaccine be given to me or to the person named above for whom I am authorized to make this request.
- I understand that if I sign below I am giving consent that my child or myself will be given the most appropriate vaccine as determined by the vaccinator.

SIGNATURE OF PERSON RECEIVING VACCINE/PARENT/GUARDIAN	DATE

CLINIC USE ONLY		Dose: <input type="checkbox"/> First <input type="checkbox"/> Second <input type="checkbox"/> Unknown				
Age Categories: <input type="checkbox"/> 6-23 mos <input type="checkbox"/> 24-59 mos <input type="checkbox"/> 5-18 yrs <input type="checkbox"/> 19-24 yrs <input type="checkbox"/> 25-49 yrs <input type="checkbox"/> 50-64 yrs <input type="checkbox"/> > 65 yrs						
2009 H1N1 VACCINE <small>CHECK BOX</small>	MANUFACTURER <small>CIRCLE</small>	LOT #/ EXP DATE <small>FILL IN</small>	DOSE <small>CIRCLE</small>	ROUTE <small>CIRCLE</small>	SITE <small>CIRCLE</small>	CDC VIS <small>CIRCLE</small>
<input type="checkbox"/> MULTI DOSE VIAL	SANOFI-PASTEUR		0.25ML	IM	RT LT	10/02/2009
	NOVARTIS		0.5ML			
	CSL					
<input type="checkbox"/> SINGLE DOSE SYRINGE, PEDIATRIC	SANOFI-PASTEUR		0.25 ML			
	NOVARTIS		0.5 ML			
	CSL					
<input type="checkbox"/> SINGLE DOSE INTRANASAL SPRAYER	MEDIIMUNE		0.2 mL	INTRANASAL		
SIGNATURE OF VACCINE ADMINISTRATOR					DATE	



State of New Hampshire
2009-2010 H1N1 Influenza Vaccine Registration and Consent
VACCINE ADMINISTRATION RECORD



Name of Person to be vaccinated _____

ANSWER THE FOLLOWING QUESTIONS FOR BOTH INACTIVATED AND INTRANASAL H1N1 VACCINE. THE ANSWERS WILL DETERMINE WHICH VACCINE IS APPROPRIATE FOR ADMINISTRATION AFTER BEING REVIEWED BY MEDICAL SCREENING STAFF AT THE CLINIC.

INACTIVATED H1N1 INFLUENZA VACCINE SCREENING QUESTIONS	Yes	No	DON'T KNOW
1. IS THE PERSON SICK TODAY?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. DOES THE PERSON HAVE A SEVERE ALLERGY TO EGGS OR A COMPONENT OF THE VACCINE?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. HAS THE PERSON EVER HAD A SERIOUS REACTION TO INFLUENZA VACCINE IN THE PAST?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. HAS THE PERSON TO BE VACCINATED EVER HAD GUILLAIN-BARRÉ SYNDROME?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. IS THE PERSON YOUNGER THAN 6 MONTHS OLD?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
INTRANASAL H1N1 INFLUENZA VACCINE SCREENING QUESTIONS	Yes	No	DON'T KNOW
1. IS THE PERSON SICK TODAY?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. IS THE PERSON YOUNGER THAN 2 YEARS OR OLDER THAN 49 YEARS?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. IS THE PERSON PREGNANT OR COULD BECOME PREGNANT WITHIN THE NEXT MONTH?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. IS THE PERSON YOUNGER THAN 5 YEARS, AND A DOCTOR HAS SAID SHE/HE HAS ASTHMA OR WHEEZING IN THE PAST YEAR?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. DOES THE PERSON HAVE A LONG-TERM HEALTH PROBLEM WITH HEART DISEASE, LUNG DISEASE, ASTHMA, KIDNEY DISEASE, NEUROLOGIC OR NEUROMUSCULAR DISEASE, LIVER DISEASE, METABOLIC DISEASE (E.G., DIABETES), OR ANEMIA OR ANOTHER BLOOD DISORDER?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. DOES THE PERSON HAVE A WEAKENED IMMUNE SYSTEM BECAUSE OF HIV/AIDS OR ANOTHER DISEASE THAT AFFECTS THE IMMUNE SYSTEM, LONG-TERM TREATMENT WITH DRUGS SUCH AS HIGH-DOSE STEROIDS, OR CANCER TREATMENT WITH RADIATION OR DRUGS?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. DOES THE PERSON HAVE A SEVERE ALLERGY TO EGGS OR COMPONENT OF THE FLU VACCINE?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. HAS THE PERSON EVER HAD A SERIOUS REACTION TO A FLU VACCINE IN THE PAST?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. IS THE CHILD OR TEEN TO BE VACCINATED RECEIVING ASPIRIN THERAPY OR ASPIRIN-CONTAINING THERAPY?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. HAS THE PERSON EVER HAD GUILLAIN-BARRÉ SYNDROME?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. DOES THE PERSON EXPECT TO HAVE CLOSE CONTACT WITH SOMEONE WHOSE IMMUNE SYSTEM IS SEVERLY COMPROMISED AND WHO MUST BE IN A PROTECTED ENVIRONMENT (SUCH AS A HOSPITAL WITH REVERSE AIR FLOW)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. HAS THE PERSON RECEIVED ANY OTHER VACCINATIONS IN THE PAST 4 WEEKS? PLEASE NOTE: NASAL SPRAY FOR SEASONAL AND H1N1 SHOULD NOT BE GIVEN AT THE SAME TIME AND SHOULD BE SEPARATED BY 4 WEEKS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>