

# McHenry County H1N1 Influenza Vaccine Administration Record

Clinic Site:  
Date:

### INFORMATION ABOUT PERSON RECEIVING VACCINE: (PLEASE PRINT)

LAST NAME	FIRST NAME	MI	DATE OF BIRTH (MM/DD/YYYY) / /	GENDER (circle) M F
ADDRESS	APT	CITY	STATE	ZIP
COUNTY	PHONE NUMBER ( ) -			

### IS THE PERSON RECEIVING THE VACCINE:

(Put a 'X' in the appropriate box below)

	YES	NO
Pregnant?		
A person who lives with or cares for a child under 6 months old?		
A healthcare worker or emergency personnel?		
A person between 6 months and 24 years old?		
A person 25 through 64 years old with chronic disease or compromised immune system?		
A healthy person aged 25-64 years?		
A healthy person over 65 years old?		
Had an intranasal vaccine within the past 30 days?		

### TO BE FILLED OUT BY VACCINE RECIPIENT, PARENT OR CLINIC PERSONNEL:

(Put a 'X' in the appropriate box below)

	YES	NO
Have you ever had a flu shot?		
Have you ever had a reaction to the flu shot or intranasal vaccine?		
Are you in general good health today?		
Are you allergic to eggs, chicken protein, latex or Thimerosal (found in contact lens solution or mercurochrome)?		
Have you ever had Guillain-Barré Syndrome? (A disorder which affects the nervous system causing paralysis.)		
If recipient is under 18 years old, do they have a chronic disease or compromised immune system?		

I have received and read the H1N1 Vaccination Information Statement dated 10/2/09

I have had a chance to ask questions that were answered to my satisfaction.

I believe that I understand the benefits and risks of the H1N1 influenza vaccine and ask that the vaccine be administered to the person named above for whom I am authorized to make this request.

I acknowledge I have had the opportunity to review a copy of the Notice of Privacy Practices which is available upon request.

If this is consent for a school-based clinic, I authorize the school district to disclose this form to the McHenry County Department of Health and to the health system conducting this clinic.

Signature of person receiving vaccine or parent/guardian of child receiving vaccine

X Relationship: \_\_\_\_\_ Date: \_\_\_\_\_

### TO BE FILLED OUT BY CLINIC PERSONNEL:

	Manufacturer	LOT #	Dose (circle)		Site of Injection (circle)		Administered by
			1 <sup>st</sup>	2 <sup>nd</sup>	Lt arm Lt leg	Rt arm Rt leg	
Inactivated							
LAIV							