H1N1 Flu Vaccination Registration Form

Public Health Department
Santa Clara Valley Health & Hospital System

Please Print Clearly – Thank You

Patient Information

Name of Patient:	Date of Birth:	Age:	Male Female
Address:	City:	Zip Code	Phone:

Patient Screening Questions:

The following questions will help us to determine whether it is safe for you to receive an influenza vaccine

	CIRCLE ONE	***Staff Comments***
1. Are you pregnant?	YES NO	
2. Are you allergic to eggs, chicken, neomycin, or polymyxin?	YES NO	
3. Ever had any bad reaction to a flu shot?	YES NO	
4. Ever had Guillain-Barré Syndrome?	YES NO	
5. Do you feel sick today or have a fever?	YES NO	
6. Are you interested in receiving the vaccine via nasal spray? You may qualify if you are healthy, ages 2 to 49 yrs. old and not pregnant or breastfeeding.	YES NO	

VACCINE ADMINISTRATION CONSENT SIGNATURE

I have read or had explained to me the “2009 H1N1 Inactivated Influenza Vaccine Information Statement, 10/2/09”. I have had an opportunity to ask questions which were answered to my satisfaction. I understand the risks of H1N1 influenza vaccine and request that H1N1 influenza vaccine be given to me or to the person for whom I am authorized to make this request.

Authorized Signature_______________________________________ Date____________________________

(Please circle: Self / Parent / Guardian)

To be completed by vaccinator/administration only:

Dosage	Dose #	Date Given	Site	Manufacturer	Lot #	VIS Date	Given By
6–35 mos. 0.25ml ***6-35 mos. 0.25ml (PF)*** **36 mos. – 9 Yrs. 0.5ml**	1st dose 2nd dose		LT RT LD RD			10/2/09	
≥10 Yrs 0.5ml ***Pregnant 0.5ml (PF)***	1st dose						