

## H1N1 VACCINE ADMINISTRATION RECORD

**PLEASE PRINT AND COMPLETE ALL SHADED AREAS.** You may also fill out this form online

<b>Name: Last</b>	<b>First</b>	<b>Middle Name</b>	<b>Date of Birth</b>	<b>Age</b>	<b>Sex</b>
<b>Street</b>		<b>City, State, Zip</b>		<b>Phone</b>	

### Screening Questionnaire for H1N1

	Yes	No	Unsure
1. Is the person to be vaccinated sick today?	_____	_____	_____
2. Does the person to be vaccinated have an allergy to eggs or to a component of influenza vaccine?	_____	_____	_____
3. Had the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	_____	_____	_____
4. Is the person to be vaccinated younger than age 2 years or older than age 49 years?	_____	_____	_____
5. Does the person to be vaccinated have a long-term health problem with heart disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic (e.g., diabetes), or anemia or another blood disorder?	_____	_____	_____
6. If the person to be vaccinated is a child age 2 through 4 years, in the past 12 months, has a healthcare provider ever told you that he or she had wheezing or asthma?	_____	_____	_____
7. Does the person to be vaccinated have a weakened immune system because of HIV/AIDS/any disease that affects the immune system, long-term treatment with drugs such as high-dose steroids, or cancer treatment with radiation/drug?	_____	_____	_____
8. Is the child or teen to be vaccinated receiving aspirin therapy or aspirin-containing therapy?	_____	_____	_____
9. Is the person to be vaccinated pregnant?	_____	_____	_____
10. Has the person to be vaccinated ever had Guillain-Barre syndrome?	_____	_____	_____
11. Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in a protective isolation (such as in a hospital room with reverse air flow)?	_____	_____	_____
12. Has the person to be vaccinated received any other vaccinations in the past 4 weeks?	_____	_____	_____

**\*\*Persons 11-19 yrs of age should wait 15 minutes after the injection before leaving the clinic.\*\***

Form completed by: \_\_\_\_\_

Date: \_\_\_\_\_

**Staff Use Only Below This Line**

**VIS H1N1.....10/2/09**

<u>Administration Site</u>	<u>Dose</u>
Lt Deltoid IM	0.5ml
Rt Deltoid IM	
Lt Anterior Thigh IM	0.25ml
Rt Anterior Thigh IM	
Intranasal	0.2ml

Nurse Signature \_\_\_\_\_ Date \_\_\_\_\_