



CLINIC SITE: _____

CLERK INITIALS: _____

POLK COUNTY HEALTH DEPARTMENT

PATIENT INFORMATION AND H1N1 VACCINATION CONSENT

LAST NAME: _____ FIRST NAME: _____ MI _____

BIRTHDATE: ____/____/____ AGE: _____ FEMALE MALE

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: (____) _____ COUNTY: _____

- 1. Are you allergic to eggs or Thimerosal (mercury - containing preservative used in vaccines)? YES NO
2. Have you ever had an allergic reaction or other problem after a vaccination?..... YES NO
3. Were you ever paralyzed by Guillain-Barre Syndrome?..... YES NO
4. Do you feel well today?..... YES NO
5. Do you have a long-term health problem such as heart disease, lung disease (e.g. asthma), kidney disease, metabolic disease (e.g. diabetes), or blood disorder (e.g. anemia)?.....YES NO
6. Do you have a weakened immune system because of HIV/AIDS or other disorder, long-term treatment with drugs such as steroids, or cancer treatment with x-rays or drugs?.....YES NO
7. Do you live with or have close contact with anyone with a severely weakened immune system requiring care in a protective environment?.....YES NO
8. Do you take aspirin or other salicylate medication?..... YES NO
9. Have you received a MMR (measles/mumps/rubella), varicella (chicken pox), &/or seasonal influenza nasal mist vaccine in the past 4 weeks?..... YES NO
10. Are you pregnant or could become pregnant within the next month?..... YES NO

Please circle one of the following priority groups that you belong to:

- Children less than 10 years of age receiving 2nd dose Health Care/EMS Medical Service Personnel
Household contacts/caregivers of infants less than 6 months Pregnant Women
Persons 6 months to 24 years of age Persons 25-64 years of age Persons over the age of 64

PLEASE NOTE: CONSENT IS REQUIRED FOR EVERY PATIENT

I acknowledge receipt of the "Notice of Health Information Privacy Practices" for Polk County Health Department and understand all information is confidential and can only be released with my consent. INITIALS: _____

I have received and read the information sheet for the H1N1 monovalent vaccination and have had the opportunity to ask questions. I understand the benefits and risks of the H1N1 monovalent vaccination. I authorize the healthcare providers of Polk County Health Department to administer vaccination to the patient named above.

SIGNATURE (or Legal Representative if patient under 18 years): _____ DATE: _____

VACCINATION ADMINISTERED
****STAFF ONLY****

Nurse Signature: _____

Date: _____

Influenza A (H1N1) Injection **CPT: G9142 & G9141**

Vaccine: _____ Exp. date: _____

Lot # _____ Mfr: _____

NDC # _____

Dosage: 0.50 ML OR 0.25 ML

Site of Injection Right Deltoid Left Deltoid Right Thigh Left Thigh

Influenza A (H1N1) MIST **CPT: G9142 & G9141**

Vaccine: _____ Exp. date: _____

Lot # _____ Mfr: _____

NDC # _____

VIS Date 10/2/09

Date given _____