Cooper County Public Health Center 2009 H1N1 Influenza Vaccine

(Injection or Nasal Spray Form)

Information about Individual to Receive Vaccine (Please Print)

NAME (Last)		(First)		(M.I.)
MOTHERS MAIDEN NAME (LAST)			**DATE OF BIRTH** **Month_______ Day______ Year _________**	**AGE**
ADDRESS				
CITY	**STATE**	**ZIP**	**DAYTIME PHONE NUMBER:**	

Screening for Vaccine Eligibility

The answers to the following questions will help us to determine if you can get the 2009 H1N1 influenza vaccine. Please mark YES or NO for each question.	**YES**	**NO**
1. Are you ill today?	☐	☐
2. Do you have a serious allergy to eggs?	☐	☐
3. Do you have any other serious allergies? Please list: ____	☐	☐
4. Have you ever had a serious reaction to a previous dose of influenza vaccine?	☐	☐
5. Have you ever had Guillain-Barré Syndrome? (Guillain-Barré Syndrome is a type of temporary severe muscle weakness)	☐	☐

Your answers to the following questions will help us know which type of vaccine you can receive. (Injection or Nasal Spray)	**YES**	**NO**
1. Have you gotten vaccinated with any vaccine (not just flu) within the past 30 days? Vaccine: _____________________________________ Date given: Month______Day_______Year___________	☐	☐
2. Do you have any of the following: Asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood?	☐	☐
3. Are you on long-term aspirin or aspirin-containing therapy? (For example, do you take an aspirin every day?)	☐	☐
4. Do you have a weak immune system? (For example, from HIV, cancer, or medications such as steroids or those used to treat cancer)?	☐	☐
5. Are you pregnant?	☐	☐
6. Do you have close contact with a person who is hospitalized and in a protected environment? (For example, a hospitalized person who has had a bone marrow transplant)	☐	☐
7. Are you or have you been on an antiviral medication within the last 48 hours?	☐	☐
8. Is the person to be vaccinated younger than 2 years old or 50 years or older?	☐	☐

CONSENT FOR VACCINATION:

Signature:

I have been given a copy and have read, or had explained to me, the information in the "Vaccine Information Statement(s)," where applicable, for the vaccine(s) indicated below. I have had a chance to ask questions and had them answered to my satisfaction. I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine(s) currently due for which I have signed below be given to me or to the person named above for whom I am authorized pursuant to Section 431.058, RSMo to make this request.

Note: The vaccine for H1N1 has been declared a covered countermeasure under the Public Readiness and Emergency Preparedness Act (42 U.S.C. § 247d-6d).

I understand that student immunization records are a legal requirement in each state for a student to attend a public school. Family Educational Rights and Privacy Act (FERPA) currently include the student's immunization record as part of his or her education record. This information is not always added to the Missouri immunization information system (IIS). Under current FERPA regulations, schools are not permitted to update Missouri's IIS system without individual consent. Such consent may be parental or from a child over 18 years of age. This restriction may result in over-immunization of students, increased administrative burdens, increased difficulty enrolling children into school, and the inability of public health to prevent vaccine-preventable diseases. Therefore, I confirm my consent to submit the information captured on this form to be entered into Missouri's immunization information system. I understand that I may elect not to have my information entered into Missouri's IIS by selecting the check box below.

❑

See back for administrative use.

FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Administered/ VIS Given	Route	Dose	Injection Site	Vaccine Manufacturer	Lot Number
2009 H1N1	/ /	☐ IM ☐ Intranasal	☐ 0.25 ml ☐ 0.5 ml ☐ 0.2 ml			
Name and Title of Vaccine Administrator						