

H1N1 INFLUENZA VACCINE (TIV) CONSENT & ADMINISTRATION RECORD

PLEASE PRINT INFORMATION ABOUT PERSON TO RECEIVE VACCINE

Last Name			First Name			Middle Initial		
Street Address			Apt #		City		State	Zip
Month	Birth Date		Age	Sex		County		
	Day	Year		<input type="checkbox"/> Male	<input type="checkbox"/> Female	Home Phone		

PLEASE ANSWER THE FOLLOWING QUESTIONS:

- | | | |
|---|------------------------------|-----------------------------|
| 1. Have you ever had a serious reaction to eggs, chicken products, latex, thimerosal? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Have you had the flu shot before? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Have you ever had a serious reaction to the flu shot? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Have you ever had Guillain Barré syndrome? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Have you been ill or had a fever within the last 48 hours? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

CONSENT FOR VACCINATION

I GIVE CONSENT to the STATE/LOCAL health department and its staff to vaccinate me with this vaccine. I have received the 2009-2010 Vaccine Information Statement for the 2009 H1N1Influenza vaccine and understand the risks and benefits. I understand that the information is confidential and will only be shared with organizations or persons who are authorized by law to receive it. This includes the Minnesota Department of Health, a health care provider or health care organization providing services on behalf of myself, and anyone else authorized under law to receive it. This information will be included in the Minnesota Immunizations Information Connection registry, a secure web-based registry system for health care providers. If you choose not to have this information shared with the registry please call 1-800-657-3970.

X _____
Signature of person to receive vaccine or person authorized to make the request (parent or guardian)

Date

NURSE USE ONLY

Vaccine Mfr and Lot #: _____ Administered: _____ 2010

Site of Injection: **Deltoid** **L** **R** Pediatric dose (6-35 mos) 0.25 ml. _____ **RVL** **LVL**

Date of VIS 10/02/2009 Signature of Vaccine Administrator: _____

Accounting Staff Only: Stats Done _____ Entered in MIIC _____