

**PLEASE PRINT CLEARLY!**  
**Fill out completely FRONT & BACK!**

Clinic Site: \_\_\_\_\_  
 Grade Level: \_\_\_\_\_

**NAME:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  Male  Female  
(Last) (First) (MI) (month/day/year)  
**STREET:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **(months if under 3 years of age)**  
**CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_ **COUNTY:**  Ingham  Other \_\_\_\_\_

**Daytime PHONE:** (\_\_\_\_\_) \_\_\_\_\_ **Cell/Alternate Phone:** (\_\_\_\_\_) \_\_\_\_\_  
*If child's form, enter parent or guardian phone numbers and complete these 2 lines:*  
 Name at this number: \_\_\_\_\_ Name at this number: \_\_\_\_\_  
 Relationship to child: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

- HEALTH SCREENING QUESTIONS: (for person receiving flu shot)**
- |   | <b>NO</b>                | <b>YES (describe)</b>          |
|---|--------------------------|--------------------------------|
| 1. Had a fever within the past 2 days?  | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| 2. Any vaccines in the past 30 days?  | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| 3. Taken any influenza antiviral medications in the last week?<br><small>(ex. Tamiflu, Relenza)</small>             | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| 4. Had a serious reaction to a flu shot or other immunization?  | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| 5. History of a paralyzing disease?   | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| 6. Allergies to <input type="checkbox"/> Eggs <input type="checkbox"/> Latex <input type="checkbox"/> Antibiotics?  | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| 7. Medical conditions?<br><small>(ex. Asthma, diabetes, lung, heart, kidney, blood, immune system, cancer)?</small> | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| 8. Pregnant/possibly pregnant?  | <input type="checkbox"/> | <input type="checkbox"/>       |

**AUTHORIZATION FOR VACCINE ADMINISTRATION:**

I have read or had explained to me the information in the Vaccine Information Statement for the H1N1 Vaccine. I understand the benefits and risks of the specified vaccine. I ask that the vaccines be given to me and/or to the person named for whom I am authorized to make this request.

**PRINT HERE:** Parent/Guardian name (if patient is under 18 yrs old): \_\_\_\_\_

**SIGN HERE:** Patient or parent/guardian(if patient is under 18 yrs old): \_\_\_\_\_

*Staff Use Only Below this Line*

Medical Screener Signature: \_\_\_\_\_ Highlight dosing below!  
 Or  Vaccine not given. Reason: \_\_\_\_\_

Vaccine <b>H1N1 Influenza</b>	Date Vaccine/ VIS Given	Vaccine Manufacturer	Vaccine Lot #	Site <sup>1</sup>	Vaccine Administrator	VIS Date
<input type="checkbox"/> IM .50		<i>Injectable:</i> <input type="checkbox"/> Novartis <input type="checkbox"/> SP <input type="checkbox"/> GSK <input type="checkbox"/> CSL				10/2/09
<input type="checkbox"/> IM Prfill .50						
<input type="checkbox"/> IM .25						
<input type="checkbox"/> IM Prfill .25						
----- <input type="checkbox"/> <b>NASAL</b>		<i>Nasal:</i> <input type="checkbox"/> MedImmune				

<sup>1</sup> Site Key: LA = left arm, RA = right arm, LL = left leg, RL = right leg, N = nasal

**INSURANCE INFORMATION**

Your insurance will be billed for an administration fee only.  
The H1N1 vaccine is provided through the United States government.

**CLIENT**

**NAME:** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_  Male  Female  
(Last) (First) (MI) (month/day/year)

**INSURANCE NAME:** \_\_\_\_\_

**Group Number:** \_\_\_\_\_

**Policy Number/Subscriber ID/Contract Number:** \_\_\_\_\_  
(write ALL numbers and letters)

**Medicaid: Recipient ID** \_\_\_\_\_

**Primary Insured:**

**Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Relationship to client:** \_\_\_\_\_

**Address (if different than client's):** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

I authorize the release of any information necessary to process insurance claims for immunization services.  
I request that any money due me for medical benefits be assigned to Ingham County Health Department.

**SIGN HERE:** (Insured Person Signature) \_\_\_\_\_ **Date:** \_\_\_\_\_