

**H1N1 Influenza Injectable Vaccine Request Form**

I have received a copy of the H1N1 Influenza Vaccine Information Statement and have read the information or had it explained to me. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and ask that the vaccine be given to me or the person named below for whom I am authorized to make this request. I have viewed the notice of Privacy Practices provided by the Mason County Health Department.

**IF YOU ARE ON MEDICARE OR MEDICAID/DPA, PLEASE WRITE YOUR NAME AND NUMBER EXACTLY AS IT APPEARS ON YOUR CARD**

MEDICARE #	DPA #	PHONE
------------	-------	-------

LAST NAME	FIRST NAME	MIDDLE	BIRTHDATE (mm/dd/yy)	AGE
STREET ADDRESS		CITY	COUNTY	STATE
				ZIP
AUTHORIZED SIGNATURE OF RECIPIENT OR PARENT/GUARDIAN			DATE:	
x				

H1N1 Influenza 2009-2010 **PLEASE ANSWER THE FOLLOWING QUESTIONS:**

1. DO YOU HAVE A FEVER TODAY	YES	NO
2. ARE YOU ALLERGIC TO EGGS?	YES	NO
3. ARE YOU ALLERGIC TO THIMEROSAL?	YES	NO

**FOR CLINIC/OFFICE USE ONLY**

**Circle vaccine given & Circle site and route**

Manufacturer	SHOT San. Pasteur	SHOT San Pasteur	(LAIV) MedImmune	SHOT (AGE 4 +)Novartis
Lot #	UPO17AA	UPO17AA	500763P	102042P1A
Dose	0.5 ml	0.25 ml (6-35months)	0.2mL (0.1/nostril)	0.5 cc
Site/route	R delt. IM L delt. IM	R delt IM R thigh IM L delt IM L thigh IM	INTRANASAL	R delt IM L delt IM

Current VIS \_\_\_\_\_10-02-09      \_\_\_\_\_10-02-09      \_\_\_\_\_10-02-09      \_\_\_\_\_10-02-09  
Given (check)

Clinic Site \_\_\_\_\_ Date \_\_\_\_\_

Signature and Title of Vaccine Administrator \_\_\_\_\_