

**2009-2010 H1N1 INFLUENZA VACCINE**  
**Wayne County Health Department**  
 Wayne, WV 25570  
 (304)272-6761

**Personal Information (Please Print Clearly):**      Date \_\_\_\_\_

**Name:** \_\_\_\_\_

**Birth Date:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Sex:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

- Have you ever had a Serious reaction to the influenza vaccine?      Yes     No
- Have you ever had a Serious allergic reaction to eggs?      Yes     No
- Have you ever had Guillain-Barre syndrome?      Yes     No
- Have you had an anti-viral within the last 48 hours?      Yes     No
- Have you already had a H1N1 shot this year?      Yes     No     When? \_\_\_\_\_

I have been given a copy and have read or have had explained to me the information sheet about H1N1 Influenza Virus Vaccine 2009-2010 dated 10/02/09 or Live, Intranasal H1N1 Influenza Vaccine dated 10/02/09. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and request that this be given to me or to the person named above for whom I am authorized to make this request. I acknowledge that I have been offered a copy of the *Notice of Privacy Practices* for the Wayne County Health Department. This notice explains how my protected health information is used and/or disclosed for the purposes of treatment, payment, and health care operations.

**Signature:** \_\_\_\_\_

**Area Below is for Staff Use Only:**

**Priority Group (must be in one of these groups to qualify)**

- Pregnant
- Household contact or a caregiver of a child under 6 months of age
- Health Care Worker
- 6 months to 24 years of age
- Between 25 and 64 and have a chronic health condition

**Screening ( If checked must have injectable)**

- Younger than 2 years of age or older than 49 years of age
- Had an MMR, Varicella, Zostavax, or Seasonal Flu Mist in last 4 weeks.
- Chronic heart or lung disease, diabetes, kidney disease, anemia, neurologic/neuromuscular, immunosuppression caused by HIV or medication or other blood disorders(not including high blood pressure).
- Pregnant or nursing
- Compromised immunity.
- Asthma

**No Contraindications were identified**

H1N1 Influenza vaccine administered.  
 Manufacturer \_\_\_\_\_ Lot # \_\_\_\_\_ Exp- \_\_\_\_\_  
 Location \_\_\_\_\_

H1N1 Flu-Mist vaccine administered.  
 Manufacturer \_\_\_\_\_ Lot # \_\_\_\_\_ Exp. \_\_\_\_\_  
 Location \_\_\_\_\_

Adm. by Signature \_\_\_\_\_

Date Admin. \_\_\_\_\_ 2<sup>ND</sup> Dose Needed