

Form D

Facility Name Missoula City-County Health Department

Patient Receiving Vaccine _____ Birth Date _____ Age _____

Address _____ City _____ State _____ Zip _____ Phone _____

I have read the 2009 H1N1 influenza vaccine information statement (VIS) and have had an opportunity to ask questions. I understand the benefits and risks of influenza vaccination as described.

- I REQUEST that the vaccine be given to me or to the person named above for whom I am authorized to sign.
- I AM CHOOSING TO DECLINE the vaccine be given to me or to the person named above for whom I am authorized to sign.

SIGN HERE

Signature of Parent/Guardian or Person Receiving Vaccine

Date

ANSWER THE FOLLOWING QUESTIONS FOR THE PERSON THAT WILL BE RECEIVING THE VACCINE:

Indicate if you fit into one or more of the groups below: (check all that apply)

- a pregnant woman (**not eligible for live virus nasal spray**)
- a person who lives with or provides care for an infant less than 6 months old
- a health-care or emergency medical services worker
- a person aged 6 months through 24 years
- a person aged 25 through 64 years who is at higher risk for influenza-related complications

If you have already been vaccinated with an influenza vaccine this season, indicate the date and type of vaccination.

- seasonal influenza vaccine nasal spray shot Date received: _____
- 2009 H1N1 influenza vaccine nasal spray shot Date received: _____

1. Are you younger than 2 years old or older than 49 years old? ____ Yes ____ No
2. Have you received any live virus vaccinations in the last 30 days? (i.e.: mmm, vzz, shingles, yellow fever) ____ Yes ____ No
3. Have you received influenza antiviral treatments in the last 48 hours? ____ Yes ____ No
4. Are you, or is anyone in your household, immunocompromised? ____ Yes ____ No
5. If you are aged 5-18 years, are you receiving aspirin or aspirin-containing therapy? ____ Yes ____ No
- ** IF YES TO QUESTIONS # 1 – 4 ABOVE, NOT ELIGIBLE FOR LIVE VIRUS NASAL SPRAY**
5. Are you allergic to eggs? ____ Yes ____ No If yes, describe your reaction _____
6. Have you ever been diagnosed with Guillain-Barre syndrome? ____ Yes ____ No
- ** IF YES TO # 1 – 6 ABOVE, NOT ELIGIBLE FOR NASAL SPRAY OR INJECTABLE FLU VACCINE**
7. Do you have any serious allergies? ____ Yes ____ No If yes, what are you allergic to? _____
- **IF YES TO #7 CHECK IF ALLERGIC TO FLU VACCINE COMPONENTS**

I authorize my health care provider and the Department of Public Health and Human Services to collect and enter my or my child's immunization records into the State of Montana Immunization Registry (WIZRD). WIZRD is a confidential, computer system that contains vaccination histories. I understand that this information in the registry may be released to county health departments as well as health care providers across the state that may provide continuing immunization services. I understand that I can revoke this authorization and have my record removed at any time by contacting my local county health department.

SIGN HERE

Signature of person to receive vaccine (or guardian)

Date

FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Dose Administered	Route	Dose Number	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator	VIS Date
<input type="checkbox"/> LAIV <input type="checkbox"/> INJ <input type="checkbox"/> INJ - PF		<input type="checkbox"/> Intranasal <input type="checkbox"/> IM					

I have reviewed all contraindications with the above recipient prior to administration of the vaccine:

Vaccine Administrator Signature _____ Date _____