

Priority Group: \_\_\_\_\_

(Please Print) Last Name First MI Birthdate Age \*\*\*25-64 See below

Street Address City State Zip Code County Phone Number

**ANSWER THESE QUESTIONS:**

**Circle One**

- Do you have an allergy to eggs or egg products? Yes No  
 Do you have an allergy to mercury containing products? Yes No  
 Do you have an allergy to Thimerosal (contact lenses or contact solution)? Yes No  
 Do you have any other known allergies? If yes, please explain Yes No  
 Have you ever had a previous reaction to the influenza vaccine? If yes, please explain Yes No  
 Are you currently ill or have a fever? Yes No  
 Are you pregnant or planning a pregnancy in the next 3 months? Yes No  
 Do you have any of the medical conditions listed below? Yes No  
 Do you have close contact with a person who has recently had a bone marrow transplant? Yes No  
 Have you had any other vaccines in the last month? (Ex: MMR, Chickenpox, etc.) Yes No  
 Have you had an influenza vaccine this season? Yes No  
 If yes, was it a nasal spray? Yes No If yes, what was the date of the immunization?

I have read or have had explained to me the information about the 2009 Novel H1N1 Influenza vaccine and I have been given a Vaccine Information Sheet (Injectable dated 10-2-09 and LAIV dated 10-2-09) on the date of this vaccine administration. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the 2009 Novel H1N1 influenza vaccine and request the vaccine be given to me or to the person named for who I am authorized to make this request. I agree to remain in the area at least 15 minutes for observation.

Signature \_\_\_\_\_

Date \_\_\_\_\_

**\*\*\*Medical Conditions:**

- Chronic pulmonary conditions: Asthma COPD Emphysema Other \_\_\_\_\_  
 Cardiovascular conditions (excludes hypertension): CHF CHD CVD Other \_\_\_\_\_  
 Renal Condition: \_\_\_\_\_ Cognitive \_\_\_\_\_ Neurologic/Neuromuscular \_\_\_\_\_  
 Hematologic \_\_\_\_\_ Metabolic: Diabetes \_\_\_\_\_  
 Immunosuppression: Medication \_\_\_\_\_ HIV Other \_\_\_\_\_  
 Long-term aspirin therapy (age 6 through 18 years)

2009 Novel H1N1 Influenza - Manufacturer/Lot #/Exp Date

Clinic location if other than MCHD

Signature of Nurse

Date Administered

Intranasal IM .25 mL .5 mL RDeltoid LDeltoid RVL LVL

**CONSENT and ACKNOWLEDGMENT**  
**Receipt of Joint Notice of Privacy Practices**

I, \_\_\_\_\_ do hereby consent to allow Madison County Health Department and its designated employees and contractors to perform personal health services. I understand the nature and consequences of any procedures to be performed will be explained to me.

I understand that the health department is already authorized to use the information gained during treatment to bill me, my insurance company, or any other potential sources of reimbursement, such as government programs in which I am enrolled or qualify for services.

I also hereby acknowledge a copy of the "Joint Notice of Privacy Practices," dated April 14, 2003, is on display at Madison County Health Department for my review and a copy is available for my taking.

\_\_\_\_\_  
Signed

\_\_\_\_\_

Date

Check if any of the following apply:

- |  |   |
|--|---|
| <input type="checkbox"/> Parent or Guardian of minor                       | <input type="checkbox"/> Health Care Surrogate                                |
| <input type="checkbox"/> Power of Attorney for Health Care                 | <input type="checkbox"/> Mental Health Treatment Preference Declaration Agent |
| <input type="checkbox"/> Guardian with power to make health care decisions |   |

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**FOR STAFF USE ONLY:**

I attempted to obtain an Acknowledgment of the Receipt of the Notice of Privacy Practices on behalf of the HD. The HD was unable to obtain the Acknowledgment because:

Client refuses to sign       Other \_\_\_\_\_ (specify):

\_\_\_\_\_ (Staff member's initials)      \_\_\_\_\_ (Date)

(Staff: Place Acknowledgment in patient's medical record.)