Massillon City Health Department * 845 Eighth St NE * Massillon, OH 44646 * 1-330-830-1710

H1N1 VACCINE ADMINISTRATION RECORD

Name (Last, First, Middle) ,		Date of Birth / /	Age ***	Sex
Street	City, State, Zip ,OH		Phone	
Clinic Site	Date of Injection 10/27/2009	Lot Number	Injeciton Site	

Is the person being vaccinated pregnant?	Yes	No
Does the person being vaccinated provide direct patient care?	Yes	No
Does the person being vaccinated care for children younger than 6 months old?	Yes	No
Does the person being vaccinated have a fever?	Yes	No
Has the person being vaccinated had a severe reaction to any medication or vaccines? Or, ever had an allergy to eggs, gentamicin, arginine, streptomycin, neomycin, polymixin B, thimerosal, gelatin, or latex?	Yes	No
Has the person being vaccinated ever had Guillain-Barre syndrome?	Yes	No
Has the person being vaccinated received any vaccine in the past 30 days?	Yes	No
Does the person being vaccinated have any of the following: asthma, diabetes, or disease of the lungs, heart, kidneys, liver, nerves, or blood?	Yes	No
Is the person being vaccinated a child that is on long-term aspirin or aspirin-containing therapy?	Yes	No
Does the person being vaccinated have a weakened immune system?	Yes	No
Does the person being vaccinated have close contact with a person who needs care in a protected environment (i.e. recent bone marrow transplant)?	Yes	No
If the person receiving the vaccination is 9 years of age or younger, is this their SECOND dose of the H1N1 vaccine? If yes, when was first dose? _____	Yes	No

I have read the Vaccine Information Statement. I have had the chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks and ask that the vaccine be given to me or to the person named on the front of this sheet for whom I am authorized to make the request. I grant permission for this record to be released to medical providers, health depts., and schools to transmit the immunization history. I also acknowledge that I have read or received a copy of the Notice of Privacy Practices (HIPAA).

Signature of person receiving vaccine or parent/guardian authorized to make the request:

X_____ Date: _____

**********Massillon City Health Department Use Only**********

MedImmune(Flu Mist)	Sanofi	Novartis
500757P	UP002AA	1008131P

Site: RD LD LT RT Vaccinator: _____

10/27/2009