

Minnesota 2009 H1N1 Influenza Vaccine

Bloomington Public Health, 1900 W. Old Shakopee Rd., Bloomington, MN 55431

Information about Individual to Receive Vaccine (Please Print)

NAME (Last)	(First)	(M.I.)	BIRTHDATE	AGE	GENDER M F
ADDRESS	CITY	STATE	ZIP	DAYTIME PHONE NUMBER	
Medicare #	Insurance Company		ID#	Group #	
Policyholder's Name	Policyholder's Birthdate		Relationship to vaccine recipient	Mother's Maiden Name	

The answers to the following questions will help us to determine if you can get the 2009 H1N1 influenza vaccine. Please mark YES or NO for each question.	YES	NO
1. Are you ill today?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have a serious allergy to eggs?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have any other serious allergies? Please list:	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had a serious reaction to a previous dose of influenza vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever had Guillain-Barré Syndrome (a temporary muscle weakness/paralysis)?	<input type="checkbox"/>	<input type="checkbox"/>

Your answers to the following questions will help us know which type of vaccine you can receive. (Injection or Nasal Spray)	YES	NO
1. Have you gotten vaccinated with MMR, Varicella, Zoster or FluMist within the past 28 days?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have any of the following: Asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you on long-term aspirin or aspirin-containing therapy? (For children & adolescents)	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have a weak immune system? (For example, from HIV, cancer, or medications such as steroids or those used to treat cancer)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have close contact with a person who is hospitalized and in a protected environment? (For example, a hospitalized person who has had a bone marrow transplant)	<input type="checkbox"/>	<input type="checkbox"/>
7. Are you or have you been on an antiviral medication within the last 48 hours?	<input type="checkbox"/>	<input type="checkbox"/>
8. Is the person to be vaccinated younger than 2 years old or 50 years or older?	<input type="checkbox"/>	<input type="checkbox"/>

CONSENT FOR VACCINATION:

I GIVE CONSENT to be vaccinated with the 2009 H1N1 vaccine. I have received the 2009-2010 Vaccine Information Statement for the 2009 H1N1 influenza vaccine and understand the risks and benefits.

I understand that the information contained within this record is being maintained to monitor immunization needs in order to prevent disease. This information is confidential and will only be shared with organizations or persons who are authorized by law to receive it. This includes the Minnesota Department of Health, a health care provider or health care organization providing services on behalf of the child, the child's school or childcare and anyone else authorized under law to receive it. This information will be included in the Minnesota Immunization Information Connection Registry, a secure web-based registry system for health care providers. If you choose not to have your child's information shared with the registry please call 1-800-657-3970.

Signature of person receiving vaccine or Parent/Legal Guardian:

Sign: _____ Date: _____
(Vaccination will not be administered if this consent form is not signed and dated.)

FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Administered/ VIS Given	Route	Dose	Injection Site	Vaccine Manufacturer	Lot Number	Expiration Date
2009 H1N1 Monovalent Influenza Vaccine		<input type="checkbox"/> IM	<input type="checkbox"/> 0.25 ml <input type="checkbox"/> 0.5 ml	RA LA RT LT	Sanofi Pasteur	UP016AA	3/30/2011
					Sanofi Pasteur	UP019AA	04/02/2011
					Sanofi Pasteur	UP026AA	04/19/2011
		<input type="checkbox"/> Intranasal	<input type="checkbox"/> 0.2 ml	Intranasal	Novartis	102045P1	3/31/2010
					Novartis	101326 2P	02/2010
					MedImmune	500756P	1/25/2010
					MedImmune	500797P	2/19/2010
Name and Title of Vaccine Administrator							

CITY OF BLOOMINGTON
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

Effective date: July 1, 2005

The Notice of Privacy Practices tells you how the City of Bloomington may use or disclose information about you. Not all situations will be described. The City of Bloomington is required to give you a notice of our privacy practices for the information we collect and keep about you.

I, _____ (Client's name), have been given a copy of the City of Bloomington's Notice of Privacy Practices and have had the chance to ask questions about how my information will be used.

Signature of Client or Personal Representative

Date

If signed by personal representative, relationship to client: _____

**This document can be made available in alternate formats that meet the
guidelines for the Americans with Disabilities Act (ADA).
Contact the City of Bloomington at: Phone (952) 563-8900,
TTY (952) 563-8900 or fax (952) 563-8997.**

For Office Use Only

We made the following efforts to obtain written acknowledgement of receipt of the Notice of Privacy Practices:

However, acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify):

