

Form D

CENTRAL MONTANA HEALTH DISTRICT / FERGUS COUNTY NURSES OFFICE

Patient Name (please print) _____ Birth Date _____ Age _____

Address _____ City _____ State _____ Zip _____ County/ Tribal Affiliation _____

Parent/ Guardian Name (if under 18 years) _____ Phone Number _____

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 _____ 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
- 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: _____

Have you received any other vaccinations in the last 30 days? ___ Yes ___ No

Have you received influenza antiviral treatments in the last 48 hours? ___ Yes ___ No

Are you, or is anyone in your household, immunocompromised? ___ Yes ___ No

If you are aged 5-18 years, are you receiving aspirin or aspirin-containing therapy? ___ Yes ___ No

Have you ever been diagnosed with Guillain-Barre syndrome? ___ Yes ___ No

Do you have any serious allergies? ___ Yes ___ No If yes, what are you allergic to? _____

Are you allergic to eggs? ___ Yes ___ No If yes, describe your reaction _____

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"/> Intranasal					10/2/2009
<input type="checkbox"/> INJ		<input type="checkbox"/> IM					
<input type="checkbox"/> INJ - PF							