Transylvania County Department of Public Health
H1N1 Vaccination Program 2009

Statement of Understanding, Permission, and Assignment

Coverage Information: ☐ No Medical Insurance ☐ Medicare ☐ Medicaid
☐ Health Choice ☐Humana ☐ Other 3rd Party Coverage

Number: _____

By signing my name below, I voluntarily give my permission to receive H1N1 Influenza Vaccine. I understand that payment of an administration fee may be made. I hereby authorize the provided or the service to release information necessary for the processing of any claim for payment and I authorize payment to the provider for such claim

_____ _____

Signature (Parent/Guardian if less than 18 years) **Date**

Name: _____ _____ _____
Last Name First Name MI

Date of Birth: _____ / _____ / _____ **Age:** _____ **Male ☐ Female ☐**
Month Day Year

Priority Group (Check ALL that Apply):
☐ Pregnant Women ☐ Household/Caregiver child <6months ☐Healthcare/EMS
☐ 6 months – 24 years ☐ 25 years-64 years with medical condition associated with high risk
☐ None of the above

Home Address: _____ _____, NC _____
Street Address City Zip Code

Contact Information:

_____ (____) ____-_____ (____) ____-____
Parent/ Guardian Name (if applicable) Home Phone Number Work/Mobile Phone Number

☐ **For parent of child less than 10 years**, I understand that my child will need a second dose of H1N1 flu vaccine after approximately one month.
☐ **For all Patients**, I understand that this vaccine is provided at no cost to me and that I will receive the vaccine for which I best qualify based on the answers I have given. I have received the appropriate Vaccine Information Statement (VIS) and my questions have been answered to my satisfaction.

I acknowledge that I have received a copy of the TCDPH Notice of Privacy (NOP) Practices and understand that I may contact the person named therein if I have questions.

_____ _____

Signature (Parent/Guardian if less than 18 years): **Date:**

Name: _____ _____ **Age:** _____
Last Name First Name

The following questions will help us to know if you or your child can get the 2009 H1N1 influenza vaccine. Please mark YES or NO for each question for the person receiving the vaccine.

A. If you answer "NO" to all four of the following questions, your or your child can probably get the influenza vaccine.
If you answer "YES" to one or more of the following four questions, you or your child *may not* be able to get the 2009 H1N1 vaccine. A nurse will review this information with you before giving the vaccine.

Please answer the following questions as it pertains to you or your child.	**YES**	**NO**
1. Have a serious allergy to eggs, gentamicin, gelatin, MSG or arginine (all contained in the flu vaccine)?		
2. Have other serious allergies? Please list: _____		
3. Ever had a serious reaction to a previous dose of flu vaccine?		
4. Ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness)?		
5. Taking Tamiflu or Relenza now or within the past 2 days?		

B. There are two kinds of 2009 H1N1 influenza vaccine. Your answers to the following questions will help us know which of the two kinds of vaccine you or your child can get.

Please answer the following questions as it pertains to you or your child.	**YES**	**NO**
1. Age under 2 years or over 49 years?		
2. Vaccinated with any vaccine (not just flu) within the past 30 days? Vaccine: _____ Date given: m/d/y_____		
3. Have any of the following conditions: Asthma, Diabetes, disease of the lungs, heart, kidneys, liver, nervous or endocrine system, or blood?		
4. Have a child under 19 on long-term aspirin or aspirin-containing therapy (for example, take aspirin every day)?		
5. Have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)?		
6. Pregnant?		
7. Have close contact with a person who has severe immune deficiency and is receiving care in a protected environment such as an isolation room in a hospital (for example, someone who has recently had a bone marrow transplant)?		

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For Health Department Use Only

Triage Nurse Review:
- ☐ Person qualifies for LAIV (FluMist) Initials: _____ Date: _____
- ☐ Person qualifies for Injectable Flu Vaccine. Initials: _____ Date: _____
- ☐ Person ineligible to receive vaccine Initials: _____ Date: _____

Date	Type of vaccine	Route	Mfr Lot#	Dose (Please Circle)	Date of VIS	Nurse Initials
	Flu Mist	Intranasal		1 2	10/2/09	
	Injectable	Lt Rt		1 2	10/2/09	