H1N1 LAIV Flu Vaccination Registration Form

Please Print Clearly – Thank You

Public Health Department
Santa Clara Valley Health & Hospital System

Patient Information			
Name of Patient:	Date of Birth:	Age:	☐ Male ☐ Female

Part A: Patient Screening Question	CIRCLE ONE	Staff Comments
You are age 2 years through 49 years old	YES NO	

If you answered: **YES**: Please go to PART B **NO**: STOP HERE, you are not eligible, please consult the nurse.

PART B: Patient Screening Questions		
Have you received the seasonal flu nasal spray within the past 28 days?	YES NO	
Do you think you might be pregnant?	YES NO	
Are you breastfeeding an infant?	YES NO	
If you are under age 5, have you had past episodes of wheezing?	YES NO	
Are you allergic to eggs or chicken?	YES NO	
Are you allergic to gentamicin, gelatin, or arginine?	YES NO	
Have you ever had a serious reaction to any influenza vaccine?	YES NO	
If you are age 2 through 17, are you taking aspirin or aspirin containing products (such as bismuth subsalicylate or Pepto Bismol)?	YES NO	
Have you ever had Guillain-Barré syndrome?	YES NO	
Are you taking corticosteroids (such as prednisone)?	YES NO	
Have you taken prescription medicine for the flu in the past 48 hours?	YES NO	
Do you have ***any*** of the following: • HIV infection • Immune system disorders • Chronic lung disease • Heart disease (except high blood pressure) • Metabolic disorders • Neurologic/neuromuscular disorder • Immunosuppression caused by medication • Kidney disease • Liver disease • Asthma • Blood disorders • Diabetes • Developmental disability	YES NO	
Do you live with or care for anyone who is severely immunocompromised?	YES NO	
Do you have an upper respiratory infection or nasal congestion?	YES NO	

NOTE: Any **YES** answer makes you ineligible to receive the nasal spray vaccine. Please consult the nurse.

VACCINE ADMINISTRATION CONSENT SIGNATURE

I have read or had explained to me the "2009 H1N1 LAIV Vaccine Information Statement, 10/2/09". I have had an opportunity to ask questions which were answered to my satisfaction. I understand the risks of H1N1 LAIV influenza vaccine and request that H1N1 LAIV influenza vaccine be given to me or to the person for whom I am authorized to make this request.

Authorized Signature_______________________________ Date_______________________
(Please circle: Self / Parent / Guardian)

To be completed by vaccinator/administration only:

Dosage	Dose #	Date Given	Site	Manufacturer	Lot #	VIS Date	Given By
H1N1 LAIV ONLY 2 – 9 Yrs.	1st dose 2nd dose		Nasal			10/2/09	
10-49 Yrs.	1st dose						