

Form D

Hill County Health Department
 302 4th Avenue • Havre, MT 59501
 406-265-5481 ext. 266

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"/> INJ <input type="checkbox"/> INJ - PF | | <input type="checkbox"/> Intranasal <input type="checkbox"/> IM | | | | | 10/2/09 |

Form D

Hill County Health Department
302 4th Avenue • Havre, MT 59501
406-265-5481 ext. 266

Billing Info

Name of Insurance: _____

Policy # _____ **Group #** _____

Subscriber Name (if Spouse or Parent): _____

Subscriber Date of Birth (if Spouse or Parent): _____