



Community Health Nursing

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Public Health
 Prevent. Promote. Protect.

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 Health Officer

H1N1 INFLUENZA/ VACCINE ADMINISTRATION RECORD

Please Print

Name: _____

Address: _____

_____ Zip code _____

Date of Birth: _____ Age: _____ Phone: _____ Sex: M ___ F ___

If you answer "No" to all five of the following questions, your child may get the influenza vaccine. If you answer "Yes" to one or more of the five questions, your child may be able to get the 2009 H1N1 vaccine, but you should discuss this with your healthcare provider.

	Yes	No
Does your child have a moderate to severe acute illness (high fever) today?		
Does your child have a severe allergy to latex?		
Has your child had a severe allergic reaction to the influenza vaccine?		
Is your child allergic to eggs?		
Has your child had Guillain-Barre' syndrome?		

I have received a copy of the H1N1 Influenza Vaccine Information Statement (10/2/2009). I believe that I understand the benefits and risks of the vaccine.

- I GIVE CONSENT to the State/Local Health Department and its staff for my child, named at the top of this form, to get vaccinated with all recommended doses of this vaccine.
- I DO NOT GIVE CONSENT to the State/Local Health Department and its staff for my child, named at the top of this form, to get vaccinated with this vaccine.

Any other information you would like the health department to know about your child? _____

X _____
 Date

X _____
 Client/parent/guardian/designee Signature

For Office Use Only

VACCINE	MANUFACTURER	LOT NUMBER EXPIRATION DATE	ROUTE	DATE ADM.	VACCINATOR INITIALS
2009 H1N1 Dose 1	See Lot Sheet	See Lot Sheet	IM Nasal		
2009 H1N1 Dose 2	See Lot Sheet	See Lot Sheet	IM Nasal		