DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health
Immunization Program

H1N1 Influenza Immunization Reporting Form

Provider Information: Please Print

Provider PIN:

0	0	0	0	0	0	4	7	8	2

Patient Information: Please Print

Last name _____ **First name** _____ **MI** ____

Street _____ **Zip Code** _____

City _____ **State** ____

Date of Birth (MM/DD/YYYY) __ __ / __ __ / __ __ __ __

Race

O White O Black O Asian O Native Hawaiian/Pacific Islander O American Indian/Alaskan Native O Other

Ethnicity
Hispanic: O Y O N

Gender
O Male O Female

Priority Groups: Fill in each circle that applies.

O **Pregnant female**
O **Live with/care for an infant <6 months of age** (e.g., parents, siblings, and Daycare providers)
O **Health-care/emergency medical personnel**
O **Child 6 months through 18 years of age**
O **Young adult 19 through 24 years of age**
O **Person 25-64 years who has a health condition (e.g. asthma, diabetes, etc)**

Vaccine Information: Please Print

Vaccine Date (MM/DD/YYY) __ __ / __ __ / __ __ __ __

Lot Number _____

Complete the next section and sign after you have talked with the clinician.

1. Is the person to be vaccinated sick today? O No O Yes O Unsure
2. Does the person to be vaccinated have an allergy to eggs or to a component of the influenza vaccine including neomycin or polymixin? O No O Yes O Unsure
3. Has the person to be vaccinated ever had a serious reaction to any influenza vaccine? O No O Yes O Unsure
4. Has the person to be vaccinated ever had Guillain-Barré syndrome? O No O Yes O Unsure
5. Has the person to be vaccinated previously received a 2009 H1N1 influenza vaccination at least 21 days ago? O No O Yes O Unsure

TYPE OF VACCINE TO BE ADMINISTERED O 2009 H1N1 Shot

A filled in circle next to the vaccine type (above) and my signature (below) means that I have been provided a copy of the appropriate Vaccine Information Statement and have read, or have had explained to me, information about the disease and the vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the risks and benefits as set forth in the statement received and I ask that the vaccine, as marked, be given.

Signature: _____ Signer's Name: _____
O Patient O Parent O Guardian Print Clearly

Presentation	Dose	Site	VIS Date
O H1N1 MIV	O 0.25ml O 0.5ml	O RA O RT O LA O LT	10/02/2009

Clinician's Signature: _____