

**INFLUENZA VACCINE REQUEST FORM**

I have received a copy of the Influenza Vaccine Information Statement and have read the information or had it explained to me. I believe I understand the benefits & risks of the vaccine & ask that the vaccine be given to me or the person named below for whom I am authorized to make this request. I understand Mason County Health Department follows the Health Information Privacy Practices Act (HIPPA) and protects my medical information in accordance with federal guidelines.

**IF THE PERSON RECEIVING THIS VACCINE IS ON ALL KIDS OR MEDICAID/DPA, PLEASE WRITE THE NAME AND NUMBER EXACTLY AS IT APPEARS ON THE CARD.**

Medicaid /All Kids # _____	Medicare # _____	Day-Time PHONE _____
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LAST NAME	FIRST NAME	MIDDLE	BIRTHDATE (mm/dd/yy)	AGE
STREET ADDRESS	CITY	COUNTY	STATE	ZIP
AUTHORIZED SIGNATURE Of RECIPIENT(18 or older) OR PARENT/GUARDIAN  x			DATE:	

**PLEASE ANSWER THE FOLLOWING QUESTIONS FOR THE PERSON RECEIVING THE INFLUENZA VACCINATION:**

1. Does this person have a SERIOUS* egg allergy? (*swelling of mouth or throat, difficulty breathing, or shock)	YES	NO
2. Does this person have any SERIOUS allergy to MSG, Gentamicin, Thimerosal, or flu vaccines? If so list allergies:	YES	NO
3. Has this person ever had a serious reaction to a previous flu shot?	YES	NO
4. Has this person had any vaccinations (not just flu) within the last 30 days? If so date given : Month _____ Day _____ Year _____ Vaccine: _____	YES	NO
5. Does this person have any of the following, asthma, diabetes, metabolic disease, heart disease, disease of the kidneys, lungs, liver, nerves or blood? (Circle condition you have)	YES	NO
6. Does this person have a weak immune system? (for example: from HIV, cancer, or medications such such as steroids or medicines used to treat cancer)	YES	NO
7. Does this person have CLOSE contact with anyone who needs care in a protected environment (for example: a recent bone marrow transplant)?	YES	NO
8. Is this person pregnant?	YES	NO
9. Does this person take aspirin therapy every day?	YES	NO
10. Do you object to the release of this immunization record to medical providers, electronic immunization record (Cornerstone) or to school authorities?	YES	NO
11. If medically appropriate, I am requesting the following vaccination:	Flu shot	Nasal mist
<b>If the answer to any of the above questions is YES please consult with the nurse before immunizations are given.</b>		

**FOR CLINIC/OFFICE USE ONLY:**

Manufacturer	VFC (LAIV) MedImmune	SHOT San. Pasteur	Sanofi Pasteur (prefilled)	SHOT San Pasteur	VFC San Past.	VFC San Past.
Lot #	501103P	UH453AC	UT434AA		UT4114AA	UH442AB
Dose	0.2cc (0.1/nosril)	0.5 ml	0.5 ml (36 mo and up)	0.25 ml (6-35months)	0.25 ml (6-35months)	0.5 ml (36 mo and up)
Site/route	INTRANASAL	R delt. IM L delt. IM	R delt IM R thigh IM L delt IM L thigh IM	R delt IM R thigh IM L delt IM L thigh IM	R delt IM R thigh IM L delt IM L thigh IM	R delt IM R thigh IM L delt IM L thigh IM

Current VIS \_\_\_\_\_07-26-11      \_\_\_\_\_7-26-11      \_\_\_\_\_07-26-11      \_\_\_\_\_07-26-11      \_\_\_\_\_07-26-11      \_\_\_\_\_07-26-11  
Given (check)

Clinic Site \_\_\_\_\_ Date \_\_\_\_\_

Signature and Title of Vaccine Administrator \_\_\_\_\_

**Mason County Health Department - 1002 E. Laurel Ave., Havana, IL 62644**