

**Southwest Utah Public Health Department 2009 H1N1 INFLUENZA REGISTRATION FORM**

<b>First Name</b>	<b>Last Name</b>	<b>Female</b>	<b>Date of Birth</b>	<b>Age</b>
		<b>Male</b>		
<b>Address</b>	<b>City</b>	<b>State</b>	<b>Zip</b>	<b>Phone#</b>
<b>Race: White Asian Black Pacific Islander</b>		<b>Ethnicity: Hispanic Non-Hispanic</b>		
<b>American Indian/Alaskan Native Other</b>				

It is recommended that these groups be the first to receive the 2009 H1N1 vaccine.

**Please mark which priority group(s) you belong to:**

- Pregnant Women – injectable only
- People who live with or care for infants younger than 6 months of age
- Health care and emergency medical personnel
- Anyone from 6 months through 24 years of age
- Anyone from 25 through 64 years of age with certain chronic medical conditions or a weakened immune system

**PLEASE ANSWER THE FOLLOWING QUESTIONS FOR THE PERSON REQUESTING THE VACCINE:**

**Is the person requesting the vaccine:**

- \*Sick (with a fever) today? Yes No
- \*Pregnant? Yes No
- \*Allergic to eggs, egg proteins, latex, thimerosal, gentamicin, gelatin or arginine? Yes No
- \*On long-term aspirin therapy? (Child or adolescent) Yes No

**Has the person requesting the vaccine:**

- \*Ever had a serious reaction to influenza vaccine in the past? Yes No
- \*Ever had Guillain-Barre syndrome? Yes No
- \*Received MMR, Varicella (Chickenpox), Shingles, Yellow Fever or Seasonal Flu Mist vaccine within the last 4 weeks? Yes No
- \*Taken any antiviral medication within the last 48 hours? Yes No

**Does the person requesting the vaccine:**

- \*Have asthma or recurrent wheezing? Yes No
- \*Have a weakened immune system or any disease that affects the immune system, long-term treatment with drugs such as steroids, or cancer treatment with drugs or radiation? Yes No
- \*Have a long-term health problem with heart disease, lung disease, asthma, kidney or liver disease, metabolic disease (e.g. diabetes), anemia, or other blood disorder? Yes No
- \*Have certain muscle or nerve disorders (such as cerebral palsy) that can lead to breathing or swallowing problems? Yes No

**CONSENT FOR TREATMENT AND PRIVACY NOTICE**

I certify that the information I have provided is true and accurate. I have been given a copy and have read, or have had explained to me, the information contained in the important information statement(s) or Vaccine information sheet(s) about the disease(s). I have had a chance to ask questions, which were answered to my satisfaction.

I believe I understand the benefits and risks of the H1N1 influenza vaccine(s) indicated be given to the person named above for whom I am authorized to make this request. I agree that this information may be shared with schools, daycare centers, health care providers and others when deemed medically necessary.

I hereby release the Southwest Utah Public Health Department, and their employees, from all claims arising from such immunizations. I authorize Medicaid or insurance benefits to be paid to the Southwest Utah Public Health Department or its authorized agent and for SWUPHD or its authorized agent to release information to Medicaid or insurance companies as necessary for claims. I understand that I may be liable for all or a portion of the bill.

I will sign over to SWUPHD any amounts paid directly to the insured for services provided by SWUPHD.

**X** \_\_\_\_\_ **Date** \_\_\_\_\_  
Signature of patient or parent/legal guardian.

For Office Use Only				
<b>Medicare Part B ID#</b>		<b>or Medicare HMO Company:</b>		
<b>Adult Medicaid</b>	<b>PEHP</b>	<b>Select Health</b>	<b>Altius</b>	<b>No charge</b>

Date	Vaccine	Lot#	Dose	Site	Nurse
	Flu		0.5 mL	RD LD	
			0.25 mL	RVL LVL	
	FluMist		0.2 mL	Intranasal	