



H1N1 FLU SHOT/FLU MIST VACCINE
TOOELE COUNTY HEALTH DEPARTMENT
CLINIC CONSENT/ENCOUNTER FORM

Table with age ranges: 6-23 mo, 19-24 yr, >65 yr; 24-59 mo, 25-49 yr; 5-18 yr, 50-64 yr

Name: _____

Address: _____

Street

City

State

Zip

Phone: _____ Date of Birth: _____ Age: _____

Race: _____ Sex: Male Female

Insurance Company: _____ Policy #: _____

Medicare #: _____ (Must have Alpha) Medicaid #: _____

The person receiving the vaccine:

- Yes No Yes No
is less than six months of age has a serious allergy to eggs
has had a serious reaction to a vaccine in the past has been paralyzed by Guillain-Barre Syndrome
is pregnant is on aspirin therapy, chemo/radiation therapy
is diabetic or has another chronic illness: heart disease, lung disease, asthma, kidney or liver disease, metabolic disease, such as diabetes, anemia, and other blood disorders

Will have contact with a person with a suppressed immune system in the next 3 weeks

I have been given a copy and have read, or had explained to me, the information contained in the Vaccine Information Statement about the disease and vaccine. I understand the benefits and risks of the vaccine and request that the vaccine be given to me or the person for whom I am authorized to make this request. I agree that this information may be shared with schools, daycare centers, healthcare providers and others when medically necessary.

I have been given a copy of the Tooele County Health Department's Notice of Privacy Practices and have had a chance to ask questions about how my public health information will be used.

Client/Guardian Signature: _____ Date: _____

**** Space below for Public Health Nursing Information Only****

234 H1N1 Preservative Free Lot # Site VIS date 10/2/09
236 H1N1 Inactivated Lot # Site VIS date 10/2/09
233 H1N1 Mist Lot # Site Nasal VIS date 10/2/09

Nurse Signature: _____ Provider # _____ E _____