

# Form D

Custer County Public Health Department, 1010 Main Street – Suite 5, Miles City, MT 59301

Patient Name (please print) \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County/ Tribal Affiliation \_\_\_\_\_

Parent/ Guardian Name (if under 18 years) \_\_\_\_\_ Phone Number \_\_\_\_\_ Medicare/Medicaid # if applicable \_\_\_\_\_

I have read the 2009 H1N1 and/or 2009-10 Seasonal influenza vaccine information statement (VIS) and have had an opportunity to ask questions. I understand the benefits and risks of influenza vaccination as described.

- I REQUEST that the vaccine be given to me or to the person named above for whom I am authorized to sign.
- I AM CHOOSING TO DECLINE the vaccine be given to me or to the person named above for whom I am authorized to sign.

**SIGN HERE**

**Signature**

**Date**

ANSWER THE FOLLOWING QUESTIONS FOR THE PERSON THAT WILL BE RECEIVING THE VACCINE:

**Indicate if you fit into one or more of the groups below: (check all that apply)**

- |  |  |
|--|--|
| <input type="checkbox"/> a pregnant woman  | <input type="checkbox"/> Over the age of 64  |
| <input type="checkbox"/> a person who lives with or provides care for an infant less than 6 months old               | <input type="checkbox"/> Healthy adult 25-64 |
| <input type="checkbox"/> a health-care or emergency medical services worker  |  |
| <input type="checkbox"/> a person aged 6 months through 24 years   |  |
| <input type="checkbox"/> a person aged 25 through 64 years who is at higher risk for influenza-related complications |  |

**If you have already been vaccinated with an influenza vaccine this season, indicate the date and type of vaccination.**

- |  |                                      |                               |                      |
|--|--------------------------------------|-------------------------------|----------------------|
| <input type="checkbox"/> seasonal influenza vaccine  | <input type="checkbox"/> nasal spray | <input type="checkbox"/> shot | Date received: _____ |
| <input type="checkbox"/> 2009 H1N1 influenza vaccine | <input type="checkbox"/> nasal spray | <input type="checkbox"/> shot | Date received: _____ |

**Have you received any other vaccinations in the last 30 days?** \_\_\_ Yes \_\_\_ No

**Have you received influenza antiviral treatments in the last 48 hours?** \_\_\_ Yes \_\_\_ No

**Are you, or is anyone in your household, immunocompromised?** \_\_\_ Yes \_\_\_ No

**If you are aged 5-18 years, are you receiving aspirin or aspirin-containing therapy?** \_\_\_ Yes \_\_\_ No

**Have you ever been diagnosed with Guillain-Barre syndrome?** \_\_\_ Yes \_\_\_ No

**Do you have any serious allergies?** \_\_\_ Yes \_\_\_ No **If yes, what are you allergic to?** \_\_\_\_\_

**Are you allergic to eggs?** \_\_\_ Yes \_\_\_ No **If yes, describe your reaction** \_\_\_\_\_

I authorize my health care provider and the Department of Public Health and Human Services to collect and enter my or my child's immunization records into the State of Montana Immunization Registry (WIZRD). WIZRD is a confidential, computer system that contains vaccination histories. I understand that this information in the registry may be released to county health departments as well as health care providers across the state that may provide continuing immunization services. I understand that I can revoke this authorization and have my record removed at any time by contacting my local county health department.

**SIGN HERE**

**Signature of person to receive vaccine (or guardian)**

**Date**

**FOR ADMINISTRATIVE USE ONLY**

Vaccine	Date Dose Administered	Route	Dose Number	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator	VIS Date (circle)
<input type="checkbox"/> LAIV <input type="checkbox"/> INJ <input type="checkbox"/> INJ - PF		<input type="checkbox"/> Intranasal <input type="checkbox"/> IM					08/11/09 10/2/09