

Town of Medway  
2009 H1N1 Flu Vaccine form (for use with Adults)

Section 1: Information about Person receiving Vaccine (please PRINT)

<b>NAME</b> (Last)	(First)	(M.I.)	<b>DATE OF BIRTH</b> / /
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Section 2: Screening for Vaccine Eligibility

The following questions will help us determine if there is any reason we should not give you injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean that you should not be vaccinated. It just means that additional questions must be asked. If a question is not clear, please ask your health care provider to explain it.

	<b>YES</b>	<b>NO</b>
1. Are you sick today?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have a serious allergy to eggs or to a component of the vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had a serious reaction to a previous dose of flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had Guillain-Barre syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>

List other serious allergies: \_\_\_\_\_

Form completed by: \_\_\_\_\_ Date: \_\_\_\_\_

Form Reviewed by: \_\_\_\_\_

**\*\*Be sure you have received and read the Vaccine Information Sheet (VIS) for the H1N1 vaccine that you are receiving today\*\***

**Section 3: Permission to Share Information:**

I, \_\_\_\_\_, give permission to the individual and /or entity that administered the 2009  
 (Print your name)

H1N1 vaccine to me to share copies of the 2009 H1N1 consent form and vaccination record with my health care provider named below, as well as with the Massachusetts Department of Public Health and the local board of health in my community. I also give permission for each of this entities to share the 2009 H1N1 consent form and vaccination record with each other.

My health care provider:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

- This information is disclosed at my request and to ensure that I am appropriately vaccinated.
- This permission expires one year from the signature date.
- If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information received may no longer be protected by federal privacy regulations. State privacy regulations cover information received by the MA Department of Public Health and local boards of health.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my child's ability to obtain the vaccination.
- I understand that I may inspect or copy the protected health information to be disclosed under this permission to share
- Finally I understand that I may withdraw this permission in writing at any time by sending written notification to:

\_\_\_\_\_ VNA and Hospice of Greater Milford, 37 Birch Street, Milford, MA 01757

However, if I withdraw permission at a later date, any vaccine consent form and vaccine record already shared will not be covered by the withdrawal.

\_\_\_\_\_  
 Printed name

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Address

\_\_\_\_\_  
 Date

**Permission to share is compliant with HIPAA and FERPA requirements**

**Section 4: Vaccination Record**

Documentation of Immunization

**FOR ADMINISTRATIVE USE ONLY**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Vaccine	Date Given	Dose	Route	Dose Number (1 or 2)	Site	Vaccine Manufacturer	Vaccine Lot number	Vaccine Information Statement		Name and Title of Vaccine Administrator
								Date on VIS	Date Given	
2009 H1N1	/ /		IM IN							

Comments: \_\_\_\_\_

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