

**SUNY Cortland Screening and Immunization Documentation Form
2009-2010 H1N1 Influenza Monovalent Vaccination Program**

Patient Information

Last Name: _____ First Name: _____ Age _____ Date of Birth: _____
 C Number: _____ E-mail Address: _____ Phone #: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Mother Maiden Name: _____

Please Carefully Read and Answer the Following Questions: (circle your answer)

1	If you are between the ages of 10 and 17 years, do you take aspirin or aspirin containing medications daily? (Please inform the healthcare provider of any medications you take daily so we can carefully screen for any aspirin containing products)	Yes	No
2	Have you received the 2009-2010 seasonal influenza vaccine? If so, did you receive the nasal _____ or injection _____. How long has it been since this vaccination? _____ (days)	Yes	No
3	Do you currently feel sick or have a fever?	Yes	No
4	Are you taking any prescription medications to prevent or treat influenza? (Amantadine, Rimantidine, Tamiflu®, Relenza®) Have you taken any antivirals in the past 48 hours?	Yes	No
5	Have you ever had a serious reaction to the flu vaccine? Please describe: _____	Yes	No
6	Do you have an allergy to any of the following: eggs, chicken or egg protein, gentamicin, gelatin, arginine, neomycin, polymyxin B, thimerosal, formaldehyde? List any allergies: _____	Yes	No
7	Do you have a chronic health problem such as: heart disease, lung disease, asthma, kidney disease, diabetes, anemia, or other blood disorder?	Yes	No
8	Do you have an active neurological disease (a disease of the brain, nervous system, etc.)?	Yes	No
9	Do you have a history of Guillain-Barre Syndrome (GBS)?	Yes	No
10	Has your doctor ever told you that you have an immune system disorder? Are you currently taking long-term corticosteroids (prednisone, methylprednisolone, etc.); immunosuppressants; chemotherapy; biologic immune modulating medications such as Remicaide®, Enbrel®, Humira®, etc? If you have an inflammatory condition such as arthritis, asthma, psoriasis, inflammatory intestinal disease, etc.	Yes	No
11	Do you have HIV, cancer, or have you received an organ transplant?	Yes	No
12	Do you live with, care for, or have close contact with anyone who is severely immunocompromised or someone who has to be in protective environment (such as transplant patients)?	Yes	No
13	Have you received any vaccines in the past 30 days or do you plan to receive any vaccines in the next 4 weeks?	Yes	No
14	Is there any chance that you are currently pregnant?	Yes	No

CONSENT FOR VACCINE ADMINISTRATION

I hereby certify that the foregoing history is true and complete to the best of my knowledge; that I have received and read or have had explained to me the "Vaccine Information Statement 2009-2010" from the CDC; that I have had an opportunity to ask questions that were answered to my satisfaction, and that I do wish to receive the H1N1 flu vaccination, fully understanding the risks and the benefits thereof. I hereby consent to the administration of the H1N1 flu vaccine. Furthermore, I hereby release and forever discharge, for myself, my heirs, executors, administrators and assignees, the State of New York, the State University of New York (SUNY), SUNY Cortland, SUNY Cortland Student Health Service, and their respective employees, officers and representatives, from any and all claims, demands or causes of action, which may result from this vaccine or my immunization.

Signature _____ Date: _____

Signature of Parent/Guardian of under 17 years of age _____

ASSESSMENT BY IMMUNIZATION CERTIFIED HEALTHCARE PROVIDER:

Give <u>injectable</u> H1N1 flu vaccine today	Vaccine Information Statement (VIS) Provided: _____ Inactivated, H1N1 Influenza Monovalent Vaccine _____ Live, H1N1 Influenza Monovalent Vaccine
Give <u>intranasal</u> Live H1N1 flu vaccine today	
Do NOT give either H1N1 vaccine today	<i>Interviewer's Signature:</i> _____ Date _____

DOCUMENTATION OF VACCINE ADMINISTRATION

Live Intranasal H1N1 Influenza (MedImmune) Lot #: _____ Expiration Date: _____ Dose: 0.2 ml Route: Intranasal	Inactivated H1N1 Influenza: Manufacturer:(circle) Sanofi-Pasteur Novartis CSL Lot#: _____ Exp Date: _____ Dose: 0.5 ml Route: IM Site: Left/ Right Deltoid
Administered By: _____ Date: _____	Preceptor: _____