utah county health department
"creating healthy communities"

H1N1 Encounter Sheet

Immunization Encounter # _____

FOR OFFICE USE ONLY

Date printed on VIS: Seasonal Flu 08/11/09, H1N1 10/02/09 O:CDP/Encounter Forms/Immunizations/H1N1-Seasonal 2009

Last Name: **First Name:** **Middle Initial:**

Date of Birth: **Age:** **Gender:** ☐ **Male** ☐ **Female** **Phone #**

Mailing Address: **City:** **State:** **Zip Code:**

Race: ☐ **White** ☐ **Alaskan Native** ☐ **Black or African American** ☐ **Native American** ☐ **Asian/Pacific Islander** ☐ **Other**

Ethnicity: **Hispanic** ☐ **YES** ☐ **NO**

Circle one: **Medicaid Medicare Primary Insurance** **Plan Name:** _____

ID Number: _____ **If United Health Care, Group Number:** _____

Please answer the questions for the person receiving the shots by checking the boxes	Yes	No	Don't Know
Sick today?			
A severe allergy to eggs, gelatin, or thimerosal (a mercury preservative)?			
History of Guillain-Barre Syndrome (GBS) or unstable neurological disorder?			
Ever had a serious reaction to influenza vaccine in the past?			
Have you had a prior dose of H1N1 vaccine?			

I have been given a copy and have read or had explained to me, the information contained in the Vaccine Information Statement(s) about the disease(s) and vaccine(s). Any questions I had were answered to my satisfaction. I understand the benefits and risk of the vaccine(s) and request that the vaccine(s) indicated be given to me or the person for whom I am authorized to make this request. I certify that I have received a copy or been given the opportunity to read the Notice of Privacy Practices. I agree that the information on this form may be shared with schools, day care centers, health care providers, and others to verify immunization status, for public health studies, or when medically necessary. I hereby release the Utah County Government and their employees from all claims arising from such immunizations. I understand that if I have insurance that covers vaccines, I am not eligible for the Vaccine for Children program. I hereby authorize the Utah County Health Department to submit claims to my Medicaid, Medicare, and/or UCHD contracted insurances.

I request the following vaccine(s) be given to me today: ☐ **H1N1** **Additional questions on back** ➡

Authorized Signature: _____ __ **Relation, if other than self:**_____

Please Print Name: _____ **Date:** _____

For Office Use Only – Do Not Write Below This Line

For Office Use Only – Do Not Write Below This Line Date printed on VIS: H1N1 10/02/09

Code	Vaccine	Site	Lot #	Dose	Code	Vaccine	Site	Lot#	Dose
291	Counseling				291	Counseling			
236	Flu > 6 mo				234	Flu PF> 6mo			
236	Flu > 4 yrs			.5cc	234	Flu PF> 4 yrs			.5cc
236	Flu>18 yrs			.5cc	234	Flu PF> 18 yrs			.5cc
233	Mist	Nasal		.2cc					

Reg Person ID# _____ Nurse ID# _____ **Operator ID:**

utah county
health department
"creating healthy communities"

Screening Questionnaire for Intranasal H1N1 Influenza Vaccination

If you are between the ages of 2 and 49 yrs old, please answer this question below (please note, if you don't qualify for the intranasal, you can still receive a H1N1 vaccine … it will just be in the injectible form.

Name:_____ Date of Birth_____

Please answer the questions for the person receiving the shots by checking the boxes	**Yes**	**No**	**Don't Know**
1. Sick today?			
2. Have an allergy to eggs or to a component of the influenza vaccine?			
3. Had a serious reaction to intranasal influenza vaccine (Flu Mist) in the past?			
4. Younger than 2 years or older than age 49 years?			
5. Have a long-term health problem with heart disease, lung disease asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., diabetes), or anemia, or other blood disorders?			
6. If ages 2 through 4 years, in the past 12 months, has a healthcare provider ever told you that he or she had wheezing or asthma?			
7. Have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as high-dose steroids, or cancer treatment with radiation or drugs?			
8. Receiving aspirin therapy or aspirin-containing therapy?			
9. Pregnant or could become pregnant within the next month?			
10. Ever had Guillain-Barre' Syndrome?			
11. Live with or expect to have close contact with a person whose immune system is severely compromised and who must be in a protective isolation (such as in a hospital room with reverse aire flow)?			
12. Received any other vaccinations in the past 4 weeks?			

Client/parent/guardian: Form Completed by: _____

Screening Representative ID # _____