H1N1 **Information About Person to Receive Vaccine (Please Print)**

Last First Mi Birthdate Age

Address City/ST Zip Phone

Doctors Name: ____________________

I have read or have had explained to me the information in the Vaccine Information sheet about the vaccine that will be administered. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and know that the vaccine listed on the bottom of this sheet will be given to the person named above, or for whom I am authorized to make this request. This immunization record may be entered on the Cornerstone system at the Ogle County Health Department. **I do allow the Ogle County Health Department to supply copies of my records to schools and\or doctors offices as needed.**

Questions to Answer: Does the person receiving the vaccine have any of the following:?

	Yes	No
1. An allergy to EGGS ?		
2. An allergy to LATEX ?		
3. Any other serious allergies that you know of? If yes, please list: ____________________		
4. Ever had a serious reaction to a previous dose of flu vaccine ?		
5. Ever had Guillain-Barre' Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?		

Signature(orparent/guardian) ____________________ **Date:**____________________

(Only children 9 yrs and under will require 2 shots.)

H1N1 Influenza (first one of two)
Date given ____________
Man/Lot ____________
Site - left arm VIS ________

H1N1 Influenza (second one of two)
Date given ____________
Man/Lot ____________
Site - left arm VIS ________

Nurse: ____________ Nurse: ____________