

# H1N1 – PATIENTS AGED 2 YRS THRU 49 YRS

H1N1 Influenza Immunization Questionnaire rev: 12/9/09

For patients: The following questions will help us determine if you are eligible to receive H1N1 influenza vaccine today. **This vaccine does not protect against seasonal influenza.** Please answer these questions by checking the boxes. If the question is not clear, please ask us to explain it. The cost of the vaccine is being paid by the U.S. Government. The administration fee is \$20.00. We do not bill insurance for this service. **Injectable form of vaccine contains thimerosal (a mercury based preservative).**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Address \_\_\_\_\_ Age (years) \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone \_\_\_\_\_  
 Physician Name \_\_\_\_\_ Phone \_\_\_\_\_

		YES	NO	?
1.	Do you have a cold with nasal congestion, respiratory illness or a fever today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Have you received any vaccinations within the past month? <input type="checkbox"/> nasal H1N1 Date: _____ <input type="checkbox"/> nasal seasonal Date: _____ <input type="checkbox"/> injectable H1N1 Date: _____ <input type="checkbox"/> injectable seasonal Date: _____ <input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Are you taking any antiviral medications (Tamiflu, Relenza, amantadine)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Do you have a <u>severe</u> allergy to eggs or egg products?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Have you had a <u>serious</u> reaction after receiving a vaccination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Do you have an allergy to thimerosal (a mercury based preservative)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	Do you have a history of Guillain-Barre Syndrome or active neurological disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	Do you have any problems with your immune system (including HIV, AIDS, cancer, organ transplant recipient)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	Are you living with or in close contact with anyone with a weakened immune system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.	Are you taking corticosteroids or anti-cancer drugs or have had x-ray treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.	Are you taking aspirin or salicylates on a regular basis? (children & adolescents only)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.	Do you have lung problems (including asthma, emphysema, bronchitis, cystic fibrosis, reactive airway disease, neuromuscular)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14.	Do you have heart disease or past heart attack or stroke?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15.	Do you have any blood diseases or kidney disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16.	Do you have diabetes or other metabolic disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17.	Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Consent for immunization:**

As the patient, (or parent or guardian of minor patient), I have read the Vaccine Information Statement (10/2/09 version) and understand the benefits and risks of receiving influenza vaccine. I have discussed the above questionnaire with the representative from Ostros and qualify for immunization. I hereby request the certified representative of Ostros Drugs to administer influenza vaccine to me (or my minor) today. I will not hold Ostros, its personnel or supervising physician liable for any adverse effects resulting from administration of this vaccine. **DSHS recipients: I understand that Ostros does not bill DSHS for this service and I understand that I cannot submit billing directly.** I agree to pay the administration fee and understand it will not be reimbursed. **Private insurance patients:** I understand that Ostros does not bill all insurance companies for this service but I can submit receipts directly, although there is no guarantee of payment

**SIGN HERE →**

\_\_\_\_\_ **Patient (or Guardian of minor) Signature**

\_\_\_\_\_ **Date**

**DO NOT WRITE BELOW THIS LINE**

<input type="checkbox"/> <b>NASAL</b> Influenza A (H1N1) 2009 Monovalent Vaccine Live, Intranasal NDC# 66019-0200-10 Lot: 500822P Exp: 03/15/2010 <b>Intranasal</b>	<input type="checkbox"/> Left Arm <input type="checkbox"/> Right Arm  <input type="checkbox"/> Left Thigh <input type="checkbox"/> Right Thigh	_____ wb _____ cp _____ gg	<input type="checkbox"/> <b>INJECTABLE</b> Influenza A (H1N1) 2009 Monovalent Vaccine NDC# 49281-0640-15 Lot: UPO24AA Exp: 4/16/11 <b>Intramuscular 0.5ml dose</b>
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