

CDP Label #6



### H1N1 Vaccine Administration Record

**PLEASE PRINT:**

Name: \_\_\_\_\_ SSN: \_\_\_\_\_  
                    First                                    MI                                    Last

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Sex: M F  
                    M                    D                    Y

Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Are you allergic to eggs?      Yes      No      (Please Circle)

**Consent for Services:**

I have been provided with information about the vaccine/s I am receiving today. 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/s.

X: \_\_\_\_\_  
Signature of Client (or Parent / Guardian / P. Representative)      Date: \_\_\_\_\_

I have been given a copy or informed that a copy of the Bear River Health Department ("Health Department") *Notice of Privacy Practices - For Protected Health Information ("Notice")* is available at [www.BRHD.org](http://www.BRHD.org) which I have or will carefully review, and acknowledge my right for a more complete description and understanding of the potential uses, disclosures of and/or requests for such Protected Health Information by the Health Department.

I acknowledge that the Health Department reserves for itself the right to change the terms of its Notice at any time, and that if the Health Department does change the terms of its Notice, I acknowledge the right to obtain a copy of the current revised Notice at any Health Department office.

X: \_\_\_\_\_  
Signature of Client (or Parent / Guardian / P. Representative)      Date: \_\_\_\_\_

**Office use only**

236 H1N1 (1/2 dose)				Lot #		Site:		
236 H1N1 (full dose)				Lot #		Site:		
234 H1N1 (preservative free)				Lot #		Site:		
233 H1N1 (flu mist)				Lot #		Site: Nasal		
6-23 mo	24-59 mo	5-18 yrs	19-24 yrs	25-49 yrs	50-64 yrs	Nurses Initials:		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
						<b>290</b>	<b>291</b>	