

**2009 Influenza A (Novel H1N1) Flu
 Adopt - a - School/Head Start
 Vaccine Administration Record &
 Age Classification/Priority Group Screening Form**

1. Complete each of the following:

School Name _____							
Name: Last	First	Middle Initial	Birthdate	Sex	Race	Phone #	
Address: Street	City		County	State	Zip Code		
Medical Information. Provide information as completely as you can. All information will be kept confidential.						YES	NO
1. Does your child have a severe allergy to eggs, or the antibiotics, polymixin, or neomycin?							

A copy of the vaccine information statement for the vaccine was provided to me. I was given the opportunity to ask questions regarding the vaccine(s) and agree to its administration.

<input type="checkbox"/> I decline to have my child vaccinated.
Signature of Vaccine Recipient or His/Her Parent or Representative _____ Date _____

Signature of Vaccine Recipient or His/Her Parent or Representative _____ Date _____

For Clinic/Office Use Only

2. Priority Group Classification

High Risk Medical Condition: Chronic lung disease (including asthma); Heart disease (excluding high blood pressure); Kidney disease; Liver disease; Diabetes; Blood disorders; Brain, spinal cord or muscle illnesses that cause swallowing or lung problems; Problems with immune protection system caused by medications and/or HIV.

Select ONE priority group only.

NOTE: When more than one priority group classification applies, use the highest priority group.

Example: If a person is in age group "19-64", is "pregnant" and has a "high risk medical condition", use (Pregnant Woman). Reason: Pregnancy is in a higher group than either their age group or their high risk medical condition.

Check one box only:

- Pregnant Woman
- Household contacts of infants < 6 months
- Healthcare & emergency medical service personnel
- All children from 6 months through 18 years of age
- All young adults 19 through 24 years of age
- Persons aged 25-64 years with high risk conditions

Clinic Code: _____

Clinic Name: _____

Date Vaccinated and VIS issued: ____/____/____

Influenza A (Novel H1N1) Flu			
<i>Manufacturer and Lot Number</i>			
<i>Injection Site</i>	<i>Right</i>	<i>Arm</i>	
	<input type="checkbox"/>	<input type="checkbox"/>	
	<i>Left</i>	<i>Thigh</i>	
	<input type="checkbox"/>	<input type="checkbox"/>	
VIS Revision Date: <u>10</u> / <u>02</u> / <u>09</u>			

Prior to the administration of the vaccine(s) checked above, a copy of the vaccine information statement for each vaccine was provided to the client or representative of the child to whom the vaccine was administered. The client or his/her representative was given the opportunity to ask questions regarding the vaccine.

Signature of Vaccine Administrator/Title _____ / _____ Date _____ / _____ Time _____