

WAUKESHA COUNTY PUBLIC HEALTH DIVISION

Name of person receiving vaccine: (Last, First, Middle Initial)	Age of person receiving vaccine:
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HEALTH INFORMATION: Mark (x) "Yes" or "No" for questions 1-12

Answer the questions for the person who will be receiving the vaccine today:

- | | | |
|---|------------------------------|--|
| 1. Is the person sick today? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2. Has the person ever had a serious or allergic reaction to past flu vaccines? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 3. Has the person ever had Guillain-Barré Syndrome? (a type of severe muscle weakness) | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 4. Does the person have a bleeding disorder? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 5. Does the person have a serious allergy to EGGS , gelatin, latex, MSG, neomycin, polymyxin, gentamicin, thimerosal or any other substance? List others below: | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 6. Did the person receive any other vaccines (including FOR FLU) in the last 4 weeks? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 7. Is the person taking or just finished taking antiviral flu medications? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 8. Does the person have any chronic health problems such as: asthma, diabetes (or other metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, muscles, or blood?
<i>For a child under age 5: has the child had recurrent wheezing?</i> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 9. Does the person have a weakened immune system from a disease such as cancer or HIV, or does the person take a medication that can weaken the immune system such as steroids or anticancer drugs? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 10. Does the person have close contact with a person with a <i>severely</i> weakened immune system who is in a protective environment such as a bone marrow transplant unit? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 11. <i>For a child under age 18:</i> Is the child on long term aspirin therapy? | Yes <input type="checkbox"/> | No <input type="checkbox"/> N/A <input type="checkbox"/> |
| 12. <i>For women:</i> Are you pregnant? | Yes <input type="checkbox"/> | No <input type="checkbox"/> N/A <input type="checkbox"/> |

I have read, or have had explained to me, the 2009 Vaccine Information Statements (10-2-09) for the 2009 H1N1 Inactivated and Live, Attenuated Influenza Vaccines. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine requested and ask that the vaccine be given to me or to the person named above for whom I am authorized to make this request.

Information collected on this form will be used to document permission for receipt of the 2009 H1N1 influenza vaccine. Record of this immunization may be shared through the Wisconsin Immunization Registry (WIR) with other health care providers directly involved with the vaccinated person's care.

Check here if you DO NOT want your vaccine data shared with WIR

I acknowledge I have received or have been offered a copy of the Waukesha County Department of Health and Human Services' Notice of Privacy Practices Regarding Health Information and have been given an opportunity to discuss my concerns and questions.

➤ _____
Signature of Adult Client or Parent/Guardian

____/____/____
Date

* * * * FOR OFFICIAL USE ONLY * * * *

Staff Comments: _____
