PRINT
CLEARLY

H1N1 Patient Registration Form

Fill out form for each person getting vaccination

KEEP THIS FORM WITH YOU
BE READY TO SHOW FORM

Patient First Name	Middle Name	Last Name		
Address		City	State	Zip
Date of Birth	Age	Gender F M	Head of Household? No Yes	Email Address
Phone	Cell Phone	Receive text alert for children under 10 for 2nd dose? No Yes N/A		

Which GROUP are you in?: **(carefully review and mark the correct one)**

GROUP A
- ☐ Pregnant woman
- ☐ Live with or provide day care for children younger than 6 months
- ☐ Health care or EMS/EMT with direct patient contact
- ☐ Age 6 months to 4 years
- ☐ Age 5 years to 18 years with chronic medical condition

GROUP B
- ☐ All other health care or EMS/EMT personnel
- ☐ Everyone age 5 years to 24 years

GROUP C
- ☐ Age 25 years to 64 years with chronic medical condition

GROUP D1
- ☐ Age 25 years to 64 years without chronic medical condition

GROUP D2
- ☐ Age 65 years and older

Chronic medical conditions (if any): _____

☐ Yes	☐ No	Patient has severe (life threatening) allergies.
☐ Yes	☐ No	Patient is allergic to eggs.
☐ Yes	☐ No	Patient is moderately or severely ill today.
☐ Yes	☐ No	Patient has history of wheezing and/or asthma.
☐ Yes	☐ No	Patient has a history of Guillain-Barre syndrome.
☐ Yes	☐ No	Patient had a live vaccine immunization in last 30 days (ie, FluMist nasal spray, MMR, chicken pox, etc.)
☐ Yes	☐ No	Is this a second dose of H1N1 vaccine? (kids 9 years and under) **IF YES, DATE OF FIRST DOSE:** _____

Patient Consent

I have:
1) Received, read, and understand the H1N1 influenza Vaccine Information Statement (VIS). Click HERE to read the VIS, or you can get one at the clinic.
2) Considered my own health status, my household members and those in close physical contact.
3) Had the opportunity to discuss my medical concerns with my health care provider or a health care provider at the vaccination clinic.
4) Responded to the questions above to the best of my ability.
5) Granted permission for this record to be released to providers, health departments, school, day-care centers, community and state immunization registry databases and others as it is necessary.
6) Agreed to release the Miami County Health District from any liability.

☐ I understand the decision to be vaccinated is voluntary and agree to allow the patient to receive the H1N1 vaccine.

Signature of person to receive the vaccine or person authorized to make the request:

X _____ **CLICK HERE TO PRINT THE FORM!** Date: _____

Printed name if other than patient receiving vaccine: _____

---------- STOP ----------

Don't forget to bring this with you!