**FINDLAY/HANCOCK HEALTH DEPARTMENT, 1644 TIFFIN AVENUE, FINDLAY, OHIO 45840**

**Name:**______________________________________________________**Date of Birth:**______________**Age:**______**SS#:**___________________
(Last) (First) ( MI)

**Address** :_______________________________________________________________________________________(______)_______-_______
(Street) (City) (State) (Zip) (Township) (phone #)

| **Please answer the following questions:** | **YES** | **NO** |
|---|---|---|
| Are you allergic to latex, eggs, thimerosol, or any components of the flu vaccine? → | | |
| Are you ill today with a fever? → | | |
| Were you ever paralyzed with Guillain-Barre Syndrome? → | | |
| Do you have an active neurological disorder? → | | |
| Are you taking Coumadin or Theophylline medication? → | | |
| Are you Pregnant? → | | |
| Do you live with or are you a close contact with a child 6 months of age or younger? → | | |
| Are you a health care worker or a caregiver? → | | |
| Are you currently taking chemotherapy, steroid therapy, or a close contact with someone who is? → | | |
| Do you have a chronic illness? (If ***yes*** circle all that apply) → <br> 1. Heart Disease; 2. Diabetes; 3. Pulmonary Disease (include **Asthma**)**;** 4.Kidney Disease; 5.Other:____________ | | |

*I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment*. **(SEASONAL INFLUENZA ONLY)**

**Please Check if you have**: ____**No Insurance**

___**Private Insurance**: ________________Insurance Carrier ________________ Policy ID______________ Group #______________

___**Medicare** Beneficiary Claim Number (HIC) ________ _________ _________ - ____

___**Medicaid** Claim Number (ID) ______________________________________ MC BUCKEYE PARAMOUNT

***VACCINE ADMINISTRATION RECORD***

The doctor or clinic may keep this record in your medical file or your child's medical file. They will record what vaccine was given, when the vaccine was given, the name of the company that made the vaccine, and the address where the vaccine was given.

"I have read or have had explained to me the Vaccine Information Statement about seasonal influenza and/or H1N1 vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of influenza and/or H1N1 vaccine(s) and ask that the vaccine(s) be given to me or the person named below for whom I am authorized to make this request."

**Signature** of person to receive vaccine or person to make the request (parent or guardian): The presence of my signature also certifies that I have received a HIPAA Privacy Notice, a Vaccine Information Sheet, and I am consenting to have my information entered into the state database.

I consent to receive (or my child receive) the **Seasonal Influenza Vaccination** and the **H1N1 Vaccination.**

**Print Name**_____________________________________ **X**_____________________________________________ **Date:** ____________

*Staff Use Only:* SEASONAL INFLUENZA H1N1 #1 H1N1 #2

**VIS DATE:**

Date Vaccine Administered & VIS Given:_________________________________________________________________

Vaccine Manufacturer:_________________________________________________________________________________

Vaccine Lot Number:__________________________________________________________________________________

Site of Administration:_________________________________________________________________________________

Signature of Vaccine Administrator:_______________________________________________________________________