

Pediatric/Adolescent Screening and Immunization Documentation Form

2009 H1N1 Influenza Monovalent Vaccination Program

The following questions will help us determine if we should give your child the intranasal or the injectable influenza vaccination today. If you answer "yes" to any question, we will ask additional questions to determine which vaccine, if any, your child will receive. Please speak to your healthcare provider, if you have any questions.

Circle answers to questions 2-16:

| | | | |
|----|--|----|-----|
| 1 | What is the age of your child? _____ month _____ year | | |
| 2 | Has your child received the 2009-2010 Seasonal Influenza vaccine? | No | Yes |
| 3 | Has your child received dose #1 of the H1N1 vaccine? | No | Yes |
| 4 | Does your child currently have a respiratory illness or a fever? | No | Yes |
| 5 | Is your child taking any prescription medications to prevent or treat influenza? Have they taken antiviral medication in the last 48 hours? | No | Yes |
| 6 | Has your child ever had a serious reaction to a flu vaccine in the past? | No | Yes |
| 7 | Does your child have an allergy to any of the following: eggs, chicken or egg protein, gentamicin, gelatin, arginine, thimerosal, formaldehyde, or other vaccine components? | No | Yes |
| 8 | Does your child have a history of asthma or wheezing? | No | Yes |
| 9 | Does your child have an active neurological disease? | No | Yes |
| 10 | Does your child have a history of Guillain-Barre Syndrome (GBS)? | No | Yes |
| 11 | Does your child have heart disease, lung disease, kidney disease, metabolic disease (e.g., diabetes), anemia, other blood disorders or any other chronic health conditions? | No | Yes |
| 12 | Is your child taking aspirin or aspirin-containing therapy? | No | Yes |
| 13 | Has your doctor ever told you that your child has an immune system disorder (e.g., HIV, cancer, or organ transplant)? Is your child taking long-term steroid treatments or immunosuppressants? | No | Yes |
| 14 | Does your child live with or expect to have close contact with severely immunocompromised individuals who must be in a protective environment (such as transplant recipients?) | No | Yes |
| 15 | Is the person to be vaccinated pregnant? | No | Yes |
| 16 | Has your child received any vaccines within the last 30 days or are they going to receive any additional vaccines within the next 4 weeks? | No | Yes |

"I have read or have had explained to me the information in the 2009 Influenza Monovalent Vaccine Information Statement (VIS). I have also had a chance to ask questions and they were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine."

Signature: _____

Date: _____

Below to be completed by healthcare provider (Please complete bottom left box)

| | | | |
|--|---|-------------------------|------|
| <p>Give injectable H1N1 flu vaccine today</p> <p>Give intranasal H1N1 flu vaccine today</p> <p>Do not administer H1N1 flu vaccine today</p> | <p>Vaccine Information Statement provided (check box)</p> <p style="text-align: center;">Inactivated, H1N1 Influenza Monovalent Vaccine</p> <p style="text-align: center;">Live, H1N1 Influenza Monovalent Vaccine</p> | | |
| | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%; border: none;">Interviewer's Signature</td> <td style="width: 30%; border: none;">Date</td> </tr> </table> | Interviewer's Signature | Date |
| Interviewer's Signature | Date | | |

Vaccine Administered

| | |
|--|---|
| <p>Live Intranasal H1N1 Influenza (MedImmune – age 2yr+)</p> <p>Lot # _____</p> <p>Dose: 0.2 ml Route: Intranasal</p> | <p>Inactivated H1N1 Influenza (Novartis – age 4yr+)</p> <p>Lot # _____</p> <p>Dose (≥4yr): 0.5 ml Route: IM Left/Right Deltoid</p> |
|--|---|

| | |
|---|--|
| <p>Inactivated H1N1 Influenza (Sanofi-Pasteur – age 6mo+)</p> <p>Lot # _____</p> <p>Dose (6-35mo): 0.25mL Route: IM (6-12mo)Thigh, IM (>12mo) Deltoid</p> <p>Dose (≥36mo): 0.5mL Route: IM Left/Right Deltoid</p> | |
|---|--|

| | | |
|---|--------------------------------------|---------------------------------|
| <p>Please complete legibly (complete SSN necessary)</p> <p>Name: _____</p> <p>DOB: _____</p> <p>SSN: _____</p> | <p>Administered by: _____</p> | <p>Date</p> <p>_____</p> |
|---|--------------------------------------|---------------------------------|

**If you're not ABSOLUTELY SURE that you've been seen or registered at Kenner Army
Health Clinic**

– please complete this portion

LAST NAME, FIRST NAME, M.I. _____

SPONSOR'S SSN: 20/ _____ **DOB** _____

SEX (CIRCLE ONE) MALE FEMALE RANK _____

UNIT _____ **UNIT PHONE** _____

HOME ADDRESS: _____

LOCATION OF MEDICAL RECORDS _____

LIST ALL ALLERGIES AND SIDE EFFECTS SEEN: **NO ALLERGIES** _____

1. _____

2. _____

3. _____

DO YOU HAVE ANY OTHER HEALTH INSURANCE? ___ YES ___ NO

IF YES, PLEASE PROVIDE THE NAME OF THE HEALTH INSURANCE COMPANY _____