NOBLE COUNTY HEALTH DEPARTMENT
H1N1
INFLUENZA VACCINE ADMINISTRATION
RECORD OR PARENT/GUARDIAN OR RECIPIENT SIGNATURE

I have been given a copy of and have read or had explained to me the information in the Influenza Vaccine Information Sheet.

I have had a chance to ask questions that were answered to my satisfaction. I believe that I understood the benefits and risks of the influenza vaccine, and ask that the vaccine be given to me or to the person named below for whom I am authorized to make this request.

NAME: _____
(Last) (First) (Middle)

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ DOCTOR'S NAME: _____

DATE OF BIRTH: _____ AGE: _____ GENDER: M F

_____ DATE: _____
(Printed Name)

_____
(Signature)

Vaccine Info: INFLUENZA Vaccinator: _____

Lot#:_____ EXP 6/30/10

Route/Site _____ IM Date: _____

Date of VIS : 8/26/09

By signing above, I authorize Noble County Health Department to release to or to request from schools, day care centers, state/local health department and health care providers all immunization information relating to the above patient. The purpose of receiving/releasing this information is to monitor that the above patient receives all his/her immunizations. This information will be utilized for follow-up services provided by schools, Day care Centers, state/local health department and health care providers to the above patient, and may be released of received by oral communication, in written form, or by computer. I understand that I may revoke this authorization at any time in writing, but the request shall remain valid until revoked. A photocopy of this authorization has the same effect as an original.

Priority Group:

____pregnant women ___health care worker ____children 6 mo-5yrs ____chronically ill