



Duke Medicine

**H1N1 INFLUENZA (FLU) VACCINE
ADMINISTRATION FORM 2009-2010**

Addressograph/Patient Label

Name
MRN/History Number (Inpatient)
Account Number
Birthdate (DHF, Clinics and PDC)

Patient Name: _____ Date of Vaccination: _____

DOB: _____ History #: _____

Medical History

Please answer the following questions pertaining to the patient:

- 1. Are you allergic to thimerosal (a mercury derivative sometimes used as a preservative in the vaccine)? Yes No
- 2. Do you have an allergy to eggs or egg products so serious that medical attention was required? Yes No
- 3. If you have had the flu vaccine before, did you have any serious reaction or other problems after receiving the vaccine? Yes No
- 4. Were you ever diagnosed with a neurological problem called Guillain-Barre' syndrome after receiving the flu vaccine? Yes No
- 5. Do you have a moderate or severe illness today (Example: anything more serious than a cold or a fever over 101)? Yes No
- 6. Do you take Coumadin, Warfarin, or other blood thinners? (If the patient answers YES to this question the injection may be given with pressure applied to site for 5 minutes.) Yes No

Vaccine Qualification

Please check any that apply:

- Pregnancy Caregiver for infant under 6 months of age
- Pediatric or Young Adult (age 6 months to 24 yrs) Healthcare worker with direct patient contact
- Long-term health problem (ages 25 to 64 years):
 - Diabetes Anemia or other blood disorder Lung disease Liver disease
 - Heart Disease Asthma Kidney disease Muscle/nerve disorder (Cerebral Palsy/seizures)
 - Weakened immune system (HIV, long-term steroid use, Cancer treatment)

I have received instructions related to side effects and a Vaccine Information Sheet

Patient or Representative Signature Date

Medication Administration – to be filled out by clinic personnel

- If yes is indicated on any questions #1-5, then provider review is necessary



M20C3 Signature _____ Title _____ Pager # _____ Date/Time _____

- Medical history reviewed Dose #: _____
- Instruction sheet & VIS given to patient

- MDe/DNE NCIR

Given in the location of: Left deltoid Right deltoid L thigh R thigh

Manufacturer: _____ Lot #: _____ Expires: _____ (n/a if sticker above)

Administered By: _____