

## A. 2009 Seasonal & H1N1 Influenza and Pneumococcal Combined Consent OSIS Data Entry Form

Last Name		First Name			Middle Initial	Date of Birth ____ - ____ - ____	
Street Address		City			State	Zip	
Gender	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Ethnicity	Hispanic Origin	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Phone Number ( ) _____ - _____
Race	White <input type="checkbox"/>	Black/African American <input type="checkbox"/>	Asian <input type="checkbox"/>	American Indian/Alaskan Native <input type="checkbox"/>	Native Hawaiian/Other Pacific Islander <input type="checkbox"/>		
Mother's Maiden Name <i>Needed for children under age 18 only</i>		Medicaid Number		Medicaid Last Name		Medicaid First Name	
Medicare Number		Medicare Part B		Yes <input type="checkbox"/>	No <input type="checkbox"/>		
<b>For Clinic Use Only – Do Not Write In Grey Areas</b>							
VFC Status: 0 – Not Eligible <input type="checkbox"/> 1 – Medicaid <input type="checkbox"/> 2 – Native America <input type="checkbox"/> 3 – Native Alaskan <input type="checkbox"/> 4 – Underinsured <input type="checkbox"/> 5 – No Insurance <input type="checkbox"/> 6 – Private Insurance <input type="checkbox"/>							
Provider/Clinic Name:				Provider ID:			
Date Given	Given By (First Initial, Last Name)	Vaccine Name in OSIS	Lot Number	Site/Route (Circle number on line next to vaccine)			Dose Number (1 or 2)
		<b>Seasonal Vaccines</b>					
		Injection		1	2	3	4
		Mist		9			
		<b>H1N1 Vaccines</b>					
		Injection		1	2	3	4
		Mist		9			
		Pneumovax		1	2	3	4

## B. Advance Consent

Please indicate below whether or not you want your child to receive the H1N1 vaccine in your absence. Complete the questionnaire on the back of this page and sign.

This consent shall remain in effect for 90 days after the date signed. Please check one of the following boxes:

<input checked="" type="checkbox"/> <b>YES</b>	<input type="checkbox"/>	<input checked="" type="checkbox"/> <b>NO</b>	<input type="checkbox"/>	<b>My child CAN receive H1N1 Intranasal Vaccine without my presence.</b>
<input checked="" type="checkbox"/> <b>YES</b>	<input type="checkbox"/>	<input checked="" type="checkbox"/> <b>NO</b>	<input type="checkbox"/>	<b>My child CAN receive H1N1 Injectable Vaccine without my presence.</b>

*PLEASE COMPLETE BOTH SIDES OF THIS FORM*



### C. Screening Questionnaire for Influenza Vaccination

**Please complete the following screening questions:** The following questions will help us determine if there is any reason you should not receive H1N1 influenza vaccine

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(mo) (day) (year)

QUESTIONS	YES	NO	Don't Know
1. Is the person to be vaccinated sick today?			
2. Does the person to be vaccinated have an allergy to eggs?			
3. Has the person being vaccinated ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness)?			
4. Has the person to be vaccinated had a serious reaction to intranasal (FluMist) or injectable influenza vaccine in the past?			
5. Does the person to be vaccinated have any of the following chronic conditions such as: asthma, active wheezing, diabetes, or disease of the lungs, heart, kidneys, liver, neuro-muscular (such as seizures, cerebral palsy, etc.), or blood (such as sickle cell anemia)?			
6. Does the person to be vaccinated have a weak immune system (such as HIV, cancer, or take medications such as steroids or those used to treat cancer)?			
7. Is the person to be vaccinated on long-term aspirin or aspirin-containing therapy?			
8. Is the person being vaccinated pregnant or could she become pregnant within the next month?			
9. Does the person being vaccinated have close contact with a person whose immune system is compromised (for example, someone who has recently had a bone marrow transplant)?			
10. Has the person to be vaccinated received any other vaccinations in the past 4 weeks? If YES, list on the following lines:			
Vaccine Name:	Month	Day	Year

I, the undersigned, give my consent for myself or my child to receive vaccinations from the Oklahoma City-County Health Department. I understand that the risks and benefits for these services will be explained to me and that I will have the opportunity to ask questions. I understand that I may refuse services at any time.

I, the undersigned, do hereby authorize the Oklahoma City-County Health Department to release information from my or my child's immunization record to the following: healthcare providers, public health officials, schools, daycares, and the Department of Human Services.

I acknowledge that I have received a copy of Oklahoma City-County Health Department Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act.

I, the undersigned, authorize the release of any medical or other information necessary to process Medicare/Medicaid billing. I also request payment be assigned to the Oklahoma City-County Health Department. Medicare/Medicaid patients may receive a letter as part of Medicare/Medicaid's anti-fraud procedure. Please be aware that these letters are not seeking payment for services from patients.

Signature of patient or parent/legal guardian: \_\_\_\_\_ Relationship if other than patient: \_\_\_\_\_