

# For Each Family Member Requesting H1N1 Vaccination

## Please Print Clearly

### Family Member 1

Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Sex:  Male  Female  
Address: County of Residence \_\_\_\_\_  
Street \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_  
Zip Code \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

### Family Member 2

Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Sex:  Male  Female

### Family Member 3

Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Sex:  Male  Female

### Family Member 4

Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Sex:  Male  Female

### Family Member 5

Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Sex:  Male  Female

### Family Member 6

Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Sex:  Male  Female

### Use Back for additional Family Members

#### **For Each Family Member, you will be asked....**

Age of client.
Is client pregnant?
Is client between 2 and 4 years of age and have a history of asthma or wheeze?
Is client sick today?
Does client have serious allergy to egg or had life threatening reaction to any previous dose of flu vaccine?
Has client had Guillan-Barre' Syndrome within 6 weeks of receiving any flu vaccine?
Has client received Nasal Flu, MMR (Measles/Mumps/Rubella), Varicella (chickenpox) or Zoster (shingles) vaccine in the last 4 weeks?
Does client have chronic health problems: Asthma, Diabetes, Sickle cell, heart, lung, or kidney disease?
Is client on long-term Aspirin therapy?
Does client have a weakened immune system? (*Cancer, leukemia, AIDS, medication for cancer or on steroid therapy)?
Does client have contact with someone who has severely weakened immune system? See above* and bone marrow transplant
Has client taken antiviral medication in the last week? (Relenza or Tamiflu)