

PATIENT ACKNOWLEDGEMENT FOR 2009 H1N1 INFLUENZA VACCINATION

No shortage of 2009 H1N1 vaccine is expected, but initially the vaccine will be available in limited quantities. In accordance with Centers for Disease Control and Prevention (CDC) guidelines, individuals in the targeted groups listed below will be given priority for 2009 H1N1 immunization. First doses will be given primarily to healthcare and emergency workers with direct patient contact, then to other target groups. Once the demand for vaccine in the prioritized groups has been met at the local level, FOH will begin vaccinating others who wish to receive it.

Your signature and check mark(s) below indicate you are in one of the *"Priority Groups Targeted for Vaccination"* or have been advised by FOH staff that vaccine demand for the priority groups at your location has been met.

Employee Information (Please Print)

Name: _____ Date: _____
(Last) (First) (MI)

Work Phone: _____ Date of Birth: _____

Work Address: _____
(Street) (City) (State) (Zip)

Agency: _____ Allergies (drug/food): _____

Priority Groups Targeted for H1N1 Vaccination *(Check all that apply)*

- | | | | |
|---|---|---|--------------|
| <input type="checkbox"/> Healthcare and EMS personal (responders providing patient care) | <input type="checkbox"/> Women pregnant during flu season | | |
| <input type="checkbox"/> Household contacts and caregivers of children < 6 months old | <input type="checkbox"/> Young adults (≤ 24 yrs) | | |
| <input type="checkbox"/> Individuals (age 25 – 64) with health condition(s) that are a high risk of influenza complications; these include: | | | |
| • Chronic pulmonary (i.e., asthma) | • Cardiovascular (except hypertension) | • Renal Disease | |
| • Liver Disease | • Neuromuscular | • Blood (including sickle cell disease) | • Neurologic |
| • Metabolic Disorders (i.e., diabetes) | • Immunosuppression (caused by medications or by HIV) | | |
| • Conditions that compromise respiration (i.e., seizures) | | | |

I have received verbal or written information regarding the vaccine and questions answered to my satisfaction. The information I have provided to complete this form indicates I understand the benefits and the risks of the vaccine and are requesting the vaccine.

➔ Employee Signature _____

PRIVACY ACT NOTICE

The information obtained in the completing this form is used to assist Federal Occupational Health in carrying out its responsibilities under one or more interagency agreements with your employing agency. The collection and use of this information is consistent with the provisions of 5 USC 552a, 5 USC 7901, and Public Law 103-356.

The information will become part of your official Employee Medical File, and is to be used only for official purposes as explained and published annually in the Federal Register under OPM/GOVT-10 (the OPM system of records). Your submission of this information is **voluntary**. If you do not wish to provide the information, you are not required to do so. However, your agency work assignments and/or personnel action may depend on the availability of complete and current occupational health records.

For FOH Clinic Use Only

H1N1 Influenza Vaccine Record

Site Code: or OHC Stamp: _____	2009 H1N1 VIS Given <i>(Check if given)</i>
	Vaccine: _____
Date: _____	Lot # _____ Exp. Date: _____
RN Name: _____ <small>(Printed)</small>	Manufacturer: _____ Dose: _____
RN Signature: _____	Site: <input type="checkbox"/> L. Deltoid <input type="checkbox"/> R. Deltoid <input type="checkbox"/> Other _____