

H1N1 VACCINE ADMINISTRATION RECORD

<u>Information about person to receive vaccine</u>					Male	Female
NAME:	Last	First	MI	Birth date	Age	
ADDRESS:	Street			City	Zip	
Home/cell Phone Number				Physician		
_____ (please initial) I have been informed about the HIPAA Information.						

1. Is the person to be vaccinated sick today?	___ Yes	___ No	___ Don't know
2. Does the person to be vaccinated have an allergy? to eggs or to a component of the vaccine?	___ Yes	___ No	___ Don't know
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	___ Yes	___ No	___ Don't know
4. Has the person to be vaccinated ever had <i>Guillian-Barre</i> syndrome?	___ Yes	___ No	___ Don't know
I have read or have had explained to me the information about H1N1 novel influenza and influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of 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.			
_____		_____	
Patient Signature/ Authorized signature		Date	

PLEASE CIRCLE PRIORITY GROUP:

- **Pregnant women** because they are at higher risk of complications and can potentially provide protection to infants who cannot be vaccinated;
- **Household contacts and caregivers for children younger than 6 months of age** because younger infants are at higher risk of influenza-related complications and cannot be vaccinated. Vaccination of those in close contact with infants less than 6 months old might help protect infants by "cocooning" them from the virus;
- **Healthcare and emergency medical services personnel** because infections among healthcare workers have been reported and this can be a potential source of infection for vulnerable patients. Also, increased absenteeism in this population could reduce healthcare system capacity; _____
- **Young adults 19 through 24 years of age** because we have seen many cases of novel H1N1 influenza in these healthy young adults and they often live, work, and study in close proximity, and they are a frequently mobile population; and,
- **Persons aged 25 through 64 years who have health conditions associated with higher risk of medical complications from influenza**

Health Condition _____

Clinic _____	Date _____	RN/LPN _____	Site _____	Manufacturer – _____
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CORNERSTONE INFORMED CONSENT FORM

X Name of Participant: _____
(Last) (First) (M)
X Date of Birth: _____ Male _____ Female _____
(Month) (Day) (Year)
Participant's ID Number _____

It is important that you read the following. If there is anything that you do not understand, or if you have any questions, be sure to ASK.

Welcome to Cornerstone, a system that collects data on a wide range of health care services to individuals. These services include WIC (Women, Infants and Children); Immunizations; Case Management; Prenatal and Postpartum Care; Pediatric Primary Care; Part C Early Intervention; Breast and Cervical Cancer; Diabetes Control; and Healthy Families Illinois.

We are asking for permission to collect information about the participant and store it in a centralized computer system maintained by the Illinois Departments of Human Services and Public Health. Based on the information collected during the enrollment or registration process, we will determine whether you need further service. Only those authorized health care professionals with a direct need to know about you will have access to this information. Information may be released for service authorization, audit, and evaluation purposes. Necessary information, without any client's name, will be sent to federal agencies that fund these programs.

By signing this consent form, you agree to allow certain information to be collected by this agency/clinic. The person(s) receiving this information has a legal and ethical duty to keep the information confidential and private, and not release it to anyone else without your written permission unless the law allows it.

- A. I authorize MCHD (Cornerstone site) to collect information during the enrollment/registration process.
- B. This authorization covers all the medical, social and financial information about the participant, including: participant background and demographic information; health visit information; medical and developmental history; prenatal, birth, and postpartum data; infant/child visit data; immunization records; participant risks; problems or factors that prevent the participant from receiving proper medical care; appointments made and services received; goals and care plan; WIC food packages; program information; information required by the federal Maternal and Child Health Block Grant Program and the Part C Early Intervention Program. Any information you do not want released should be written in Part D.
- C. This authorization also covers information about mental health, AIDS, HIV, sexually transmissible diseases, alcoholism, and drug use which may be reported by me. I understand that I am not required to report or discuss those matters with anybody.
- D. The following information I do NOT want to be shared: _____
- E. I am making this consent within the limits of my legal authority. I understand that I may revoke this consent orally or in writing at any time, but that revoking this consent will not cancel what was done before I revoked it. I also understand and agree not to hold the Illinois Departments of Human Services and Public Health liable for the release of any information about me in accordance with the terms of this consent form.
- F. A photostatic copy/facsimile of this consent will be as valid as the original

For child participant: _____ OR _____
Signature of parent/legal guardian/caretaker/Date Signature of adult participant/Date
Signature of Witness: _____ Date: _____