Cherokee Regional Medical Center
HOME CHOICE – HOSPICE – PUBLIC HEALTH
300 Sioux Valley Drive Cherokee, Iowa 51012
H1N1 flu vaccine Patient Intake Information

Patient Name_____ Date of Birth_____
Address_____ City, State, Zip_____
School_____ Grade_____Doctor_____

Please answer the following questions about you or your child's health.

1. Is the patient pregnant? No Yes
2. Is the patient taking Tamiflu or other antiviral medication? No Yes
3. Has the patient been sick in the past 24 hours? No Yes
   Explain_____
4. Does the patient have allergies to medications, food, or any vaccine? No Yes
   Please circle those that apply: Eggs Latex Products containing Thimerosol or Mercury (e.g. contact lens solution, merthiolate) Other_____
3. Has the patient had a serious reaction to a vaccine in the past? No Yes
   Specify_____
4. Has the patient ever had a seizure or a brain/nerve problem? No Yes
5. Does the patient (or family member) have cancer, leukemia, AIDS, or any other immune system problem? No Yes Specify_____
6. Has the patient (or a family member) taken cortisone, prednisone, other steroids, or anticancer drugs, or had x-ray treatments in the past 3 months? No Yes Specify_____
7. Has the patient ever had a bleeding disorder, or in the past year received a transfusion of blood or blood products or been given a medicine called immune (gamma) globulin? No Yes
8. Has the patient received vaccinations in the past 4 weeks? No Yes Specify_____

⟧ I understand what immunization will be given and I give permission to have my child/patient immunized. I have received the information sheets that tell about the vaccine that will be given. I was given a chance to ask questions and my questions were answered to my satisfaction.

⟧ I hereby release Cherokee Regional Medical Center and its agencies, boards, board members, Cherokee County Board of Health, and employees from any and all liability associated with this immunization process.

⟧ I authorize release of my child/patient immunization records to schools, pre-schools, daycare providers, and physician offices per request.

⟧ The notice of privacy practices of this facility has been made available to me.

Parent/Guardian Signature_____ Date_____

**********For Office Use Only**********

Vaccine	Date	Administered by	Dose/Route/Site	Lot #

Recipient Tier Group:

_____Pregnant _____6 months—24 years old
_____Household contacts and caregivers for children younger than 6 months of age
_____Healthcare worker or emergency medical services personnel
_____25-64 years old with an underlying medical condition