Medical Record # _____

ARROYO VISTA FAMILY HEALTH CENTER

Influenza / H1N1 Form

County of Los Angeles Public Health

Please print neatly in capital letters as shown in the example: EXAMPLE 123

Person to notify in case of emergency not living with you.

Name_____ Phone #_____

Personal Information: Provide information as completely as you can. All information will be kept confidential.

First Name **Last Name** **MI**

Street Number **Street Name** **Apt. Number**

City **Zipcode** **County** O LA O Other **State** O CA O Other

Phone - -

Date of Birth M M / D D / Y Y Y Y

Age (years) If < 1 Year, age in months

Gender: O Male O Female

Race/Ethnicity: O Asian O Native Hawaiian/Pacific Islander O Hispanic/Latino O Other O Black, African American O American Indian/Alaskan Native O White

Do you have any of the following medical conditions? O YES O NO
Heart, lung, kidney, liver or neurological disease; cancer; asthma; diabetes; blood disorder; immune system disorder

Do you take care of or live in a household with a child less than 6 months of age? O YES O NO

Are you pregnant, or do you think you may be pregnant? O YES O NO

If minor, name of parent or legal guardian

I consent to the vaccination provided and allow Arroyo Vista to provide health care services.

Signature

STOP - DO NOT WRITE BELOW THIS LINE

	Seasonal LAIV	Seasonal TIV	Pan H1N1 Live	Pan H1N1 Inactivated	Screener
Contraindications?	O YES O NO	O YES O NO	O YES O NO	O YES O NO	
Vaccine To Be Administered	Dose #: O 1 O 2	Dose #: O 1 O 2	Dose #: O 1 O 2	Dose #: O 1 O 2	

	Live	Inactivated	Dosage	Site	Manufacturer / Lot Number	Admin. by
Seasonal VIS 08/11/09	O	O	O 0.25 mL O 0.50 mL O 0.2 mL	O RD O RT O LD O LT O Intranasal	O SP O Nov O GSK O CSL O MI	
Pan H1N1 VIS 10/02/09	O	O	O 0.25 mL O 0.50 mL O 0.2 mL	O RD O RT O LD O LT O Intranasal	O SP O Nov O GSK O CSL O MI	

Date Administered M M / D D / Y Y Y Y

VFC PIN

Street Number of Site

46635 Formtran