# H1N1 INFLUENZA VACCINATION CLINIC

MITMedical

**Print name:** _____ **D.O.B:** _____ / _____ / _____
First Last month day year

**Age group:** *(this is required for state reporting)*

☐ 6-23 months ☐ 24-59 months ☐ 5-18 years ☐ 19-24 years

☐ 25-49 years ☐ 50-64 years ☐ 65+ years

**MIT affiliation:**

☐ MIT student ☐ Student family member ☐ Retiree ☐ Contractor ☐ MIT employee

☐ Traditional/Flexible Health Plan Member ☐Affiliate/family ☐ Other _____

**Patient questions:**

Are you presently feeling ill or have a fever? ☐ Yes ☐ No

Do you have an allergy to eggs? ☐ Yes ☐ No
(a reaction that includes a rash, hives or difficulty breathing)

Have you had a serious reaction to previous flu shots? ☐ Yes ☐ No

Have you ever had Guillain-Barre Syndrome (a type of temporary severe muscle weakness) within 6 weeks after a flu shot? ☐ Yes ☐ No

Injection site desired: ☐ Left arm ☐ Right arm

I have received the H1N1 Vaccine Information Sheet. ☐ Yes ☐ No Initials _____

## For office use only

**Nurse administering vaccine:** _____

**Visit date:** ____ / ____ / _____ **Injection site:** ☐ Left arm ☐ Right arm

**Ordering provider:** William Kettyle, M.D.

**Immunization:** Administration
90470 One Shot Only

**Vaccine:** 90663 H1N1 Influenza **Lot #** _____

**Diag Code:** V04.81 **Exp date** ____ / ____ / _____