

SALT LAKE VALLEY HEALTH DEPARTMENT
Family Health Services – Client Encounter Document

Date: ____/____/____

Last Name: _____ First Name: _____ MI: _____

Date of Birth: ____/____/____ Age: _____ Sex: Male: _____ Female: _____

Race: Caucasian Black Asian American Indian Alaskan Native Pacific Islander Other

Hispanic: Yes No

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ - _____

YOUR PRIVACY

I have been provided the opportunity to read SLVHD's Notice of Privacy Practices, and I have had this policy explained to me. In addition I understand that I may request a copy of these practices in a reasonable alternative format (*initials*) _____. I agree that this immunization information may be shared with schools, day care centers, health care providers, and other health care professionals as necessary to verify immunization status, audits, and public health studies. In addition, I agree that this information may be shared with health care personnel or public health personnel who have a legitimate need to have access to the immunization information in order to assist a patient or to protect the health of others closely associated with the patient. I understand that I have the right to revoke this authorization at any time by notifying SLVHD in writing. This release of information will be effective until canceled in writing.

Signature (X) _____ Date ____/____/____

Relation to Patient: _____

I understand that I may refuse to sign this section. I understand that once my data is shared with another individual or agency that it may lose the protections provided by the Privacy Rule, and may be subject to re-disclosure by that recipient.

I have received a copy and have read, or had explained to me, the information contained in the Vaccine Information Statement(s) about the disease(s) and vaccine(s). I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated on this page be given to me or to the person for whom I am authorized to make this request.

I certify that the information I have provided is true and accurate. I authorize and consent to such medical testing and emergency treatment as the health care providers of the **Salt Lake Valley Health Department** may prescribe.

Signature (X) _____ Date: ____/____/____

Relation to Patient: _____

First Dose Second Dose

Encounter#

Date:

Target Groups		Yes	No
1	Care Providers or Household Members of Infants ≤ 6 months?		
2	Health Care and Emergency Services personnel?		
3	People 6 months through 24 years of age?		
4	Pregnant Women? <i>Not Eligible for H1N1 Nasal</i>		
5	Children 5 yrs to 18 yrs - Medical Conditions creating higher risk for influenza related complications? <i>Not Eligible for H1N1 Nasal</i>		
6	Adults 18 yrs to 64 yrs - Medical Conditions creating higher risk for influenza related complications? <i>Not Eligible for H1N1 Nasal</i>		

Screening Questions (H1N1 Injectable TF & H1N1 Injectable)		Yes	No
1	If this immunization is for an infant, is the infant at least 6 months of age?		
2	Do you have allergies to eggs or any components of the flu vaccine? (FluMist contains MSG, Gelatin, arginine & gentamycin)		
3	Have you ever had a serious reaction after receiving the seasonal influenza vaccine?		
4	Have you ever had Guillian-Barre Syndrome? (This is a severe paralytic illness, also called GBS)?		
5	Have you read the appropriate Vaccine Information Sheet?		

Additional Question For H1N1 Nasal		Yes	No
1	Are you less than 24 months of age or have you reached your 50th birth date?		
2	Are you pregnant, or do you think you might be pregnant?		
3	Have you taken any antiviral drugs in the past 2 weeks, such as Tamiflu or Relenza?		
4	Do you have long-term health problems, such as heart disease, kidney disease, lung disease, (including asthma, spastic or irritable airway), diabetes or other chronic disease?		
5	Do you have close contact with anyone who has a weakened immune system, such as a person who has had a bone marrow transplant?		
6	Do you have any problems with your immune system, such as cancer, treatment for cancer, HIV, leukemia, bone marrow transplant/other transplants?		
7	Do you have muscle or nerve disorders that can lead to breathing or swallowing problems, such as MS, seizures or cerebral palsy?		
8	Are you a child or adolescent receiving aspirin or aspirin containing therapy?		
9	Have you had Nasal Seasonal Influenza, MMR or Varicella vaccine in the past 28 days?		

 Screener Signature

FOR OFFICE USE ONLY

Immunizations	Lot#	Site	Dos	Rte	VIS
233 H1N1 Nasal	_____	_____	0.2 cc	IN	Oct-09
234 H1N1 Injectable TF	_____	_____	0.25 cc 0.5 cc	IM	Oct-09
CSL GSK Novartis Sanofi					
236 H1N1 Injectable	_____	_____	0.25 cc 0.5 cc	IM	Oct-09
CSL GSK Novartis Sanofi					

 Nurse/Provider Signature

 Nurse/Provider #

CDP # Insurance Plan	Data Entry
<input type="checkbox"/> Medicaid/Medicaid HMO's <input type="checkbox"/> CHIP <input type="checkbox"/> Medicare/Medicare Replacement Plans <input type="checkbox"/> Insurance Plan	Employee ID# _____ Employee Signature _____