

Henderson County Department of Public Health 2009 H1N1 Vaccination Initiative



For the person receiving the H1N1 vaccine, please check all that apply:

- Pregnant
- Health Care or Emergency Services worker
- Age 6 months through 24 years
- Lives with or provides care for an infant under 6 months
- Age 25-64 years with chronic health care condition.

Recipient: _____ Age: _____
First Name MI Last Name

Date of Birth: _____ / _____ / _____ Male Female Race: _____
Month Day Year

Ethnicity: Hispanic/Latino Y or N

Home Address: _____, NC _____
Street Address City Zip Code

Home Phone #: (____) _____ - _____ Alternate Phone #: (____) _____ - _____

If applicable, Parent/Guardian Name: _____

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of the HCDPH Notice of Privacy (NOP) Practices and understand that I may contact the person named therein if I have questions. The NOP will be available at the site or is available on our website at the bottom of the home page at www.hendersoncountync.org/health.

→ _____
Signature of Client or Responsible Party Date

CONSENT FOR VACCINATION:

- I have read or had explained to me the 2009-2010 Vaccine Information Statement for the 2009 H1N1 influenza vaccine and understand the risks and benefits. I have had a chance to ask questions that were answered to my satisfaction.
- I give consent to the Henderson County Department of Public Health for me or my child to receive the H1N1 vaccination.
- **Parents/Guardians:** I understand that if my child receives the H1N1 vaccination and h/she is under 10, a second vaccine will be needed to be fully immunized.

→ _____
Signature of Client or Responsible Party Date

