

H1N1 PATIENT CHART RECORD



STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH DIVISION
IMMUNIZATION PROGRAM
4150 Technology Way, Suite 210
Carson City, Nevada 89706

Telephone: (775) 684-5900 · Fax: (775) 883-4732 OR (775) 883-3768

FACILITY CONTACT INFO (please print)	
Facility Name:	Facility Address:
Name of Facility Representative:	
Pin Number:	Facility Phone Number:

PATIENT INFO		
Last Name:	First Name:	Date of Birth: (mm/dd/yyyy) <input type="checkbox"/> Not Available
Gender: (check one) <input type="checkbox"/> Female <input type="checkbox"/> Male	Mailing Address: <input type="checkbox"/> Not Available Street: City, County, State, Zip Code:	Physical Address: <input type="checkbox"/> Not Available Street: City, County, State, Zip Code:
Phone Number: ()		
State, Country of Birth:	Priority Group: (check all that apply) <input type="checkbox"/> Pregnant Women <input type="checkbox"/> Household contacts & caregivers for children younger than 6 months <input type="checkbox"/> Healthcare & emergency medical services personnel <input type="checkbox"/> 6 months - 18 yrs. old <input type="checkbox"/> 19 through 24 yrs. old <input type="checkbox"/> 25 - 64 yrs. old with underlying medical conditions. Identify Type: _____	Ethnicity: (check one) <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino <input type="checkbox"/> Unknown
<u>Child Only (birth-18 yrs old)</u> Mother's Full Name: Mother's Maiden Last Name:		Race: (check all that apply) <input type="checkbox"/> Caucasian <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Unknown

VACCINES <small>Circle vaccine administered</small>	DATE GIVEN	DOSE # <small>Circle dose #</small>	LOT #	SITE <small>Circle site administered</small>	ROUTE
MedImmune		1 2		Intranasal	Nasal
GSK				Left Thigh Right Thigh Left Deltoid Right Deltoid Left Arm Right Arm	Intramuscular
CSL					
Sanofi					
Novartis					

VACCINE INFORMATION STATEMENT (VIS)	VACCINATOR	
DATE VIS GIVEN TO PATIENT	NAME & TITLE OF VACCINATOR	SIGNATURE
<input type="checkbox"/> Same as Vaccine Date m m / d d / y y y y	Name: Title:	

NEVADA STATE HEALTH DIVISION OFFICE USE ONLY:		Revised 10/2009
Date Form Received	Date Recorded into Nevada WebIZ	