

7.) Does your child have a weakened immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)? YES NO

- 8.) Does your child have:
- a. Asthma or other lung disease? YES NO
 - b. Diabetes YES NO
 - c. Metabolic Disorder YES NO
 - d. Heart Disease YES NO
 - e. Kidney Disease YES NO
 - f. Liver Disease YES NO
 - g. Seizures YES NO
 - h. Cerebral Palsy YES NO
 - i. Immune System Disorder YES NO

9.) Does your child have close contact with anyone with a SEVERELY weakened immune system requiring care in a protected environment ? YES NO

Name of child's health care provider (doctor, nurse practitioner): _____

Health Insurance Company (if any) and Number: _____

Clinic Use Only

Does this child have a fever today ? : _____ **Yes** _____ **No** _____ **Initials**

FOR CLINIC USE ONLY:

Vaccine	Date Dose Administered	Route	Dose Number (1 st or 2 nd)	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator
2009 H1N1	/ /	<input type="checkbox"/> IM <input type="checkbox"/> Intranasal				
2009 H1N1	/ /	<input type="checkbox"/> IM <input type="checkbox"/> Intranasal				