



H1N1 INFLUENZA VACCINE RECORD

Information About Person To Receive Vaccine (Please Print)

_____	_____	_____
Last Name	First Name	Date of Birth
_____		_____
Mailing Address		Apt/Suite
_____	_____	_____
City	State	Zip
_____	_____	_____
Area Code	Phone Number	Parent/Guardian Name

For Clinic Use Only

Vaccination Date: _____		
Date of VIS : _____	Dosage Volume: _____	_____
		Signature of Vaccine Administrator
Admin. Site:	<input type="checkbox"/> Right Deltoid	Lot Number: _____
	<input type="checkbox"/> Left Deltoid	_____
	<input type="checkbox"/> Intra Nasal	Manufacturer: _____
		Signature Date