Saint Mary's College of California
Health and Wellness Center Immunization Program
Patient Information Form

Name: ____
(Please Print) Last First Middle Initial

Date of Birth: _____/_____/______ **Age**_____ **Student ID#** __________________

Address: ____
Street Apt.

____
City State Zip

Cell Phone: _______________________

I am not severely allergic to eggs or any other substance in the vaccine.
I have not received the Flumist Nasal Vaccine for seasonal influenza in the last 14 days.
I have no active underlying condition such diabetes, asthma, anemia, heart, lung, kidney or liver disease.
I am not pregnant.
I do not have muscle or nerve disorder such or cerebral palsy.
I am not in close contact with a person with a severely weakened immune system.

I have been given a copy and read the vaccine information statement for the 2009 H1N1 live attenuated influenza vaccine that I am requesting. I have had a chance to ask questions that were answered to my satisfaction and I believe I understand the risks and benefits of these vaccines.

Signature: ____Date ______________

Vaccine information: (for office use only)

Type of vaccine: Influenza A (H1N1) 2009 Monovalent Vaccine Live, intranasal

VIS Date: 10/2/09

Manufacturer: MedImmune **Lot**: 500780P

Expiration Date: 02/06/10

Nurse's signature: __________________________________**Date** ________________