NEW MEXICO DEPARTMENT OF HEALTH

Revised 10/1/2009

H1N1 Vaccine Administration Form

Please fill in form completely – **required** fields are marked with an asterisk (*)

Vaccine Provider Information (***You may complete this provider information and copy the form so it only needs to be completed once for your site)*:**

_____ ***PIN#:** _____

***Clinic/Hospital/Provider Name**

This was assigned on your vaccine agreement

_____

*Phone number

Information about the person being vaccinated:

Person receiving vaccine:

* Last Name: |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_| * First Name: |_|_|_|_|_|_|_|_|_|_| MI: |_|

* Date of Birth: ____/___/_____ (mm dd yyyy) * Mother's Maiden Name: |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_| (Last Name) (First Name)

* Mailing Address: |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_| * City: |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_| * State: |_|_| * Zip: |_|_|_|_|_|

* Responsible Person: |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_| (Last Name) (First Name) * Relationship: |_|_|_|_|_|_|_|_|_|_|

INSURANCE STATUS

*** For children 0–18 years of age, please mark appropriate category (select only one):**

- ☐ No health insurance
- ☐ Underinsured: has commercial (private) health insurance but coverage does not include vaccines, covers selected vaccines, or caps vaccine coverage at a certain amount
- ☐ American Indian
- ☐ Medicaid/Salud – **place check mark next to plan**:
  - __Molina Medicaid/Salud
  - __Lovelace Medicaid/Salud
  - __Presbyterian Medicaid/Salud
  - __Blue Cross Blue Shield Medicaid/Salud
  - __United Healthcare Medicaid/Salud

Private/Commercial insurance:

- ☐ Blue Cross Blue Shield
- ☐ Lovelace
- ☐ Presbyterian
- ☐ United Healthcare
- ☐ Other: _____ (**indicate company name**)

* **Sex**: ☐ Male ☐ Female * **Ethnicity**: ☐ Hispanic ☐ Non-Hispanic * **Race**: ☐ American Indian ☐ Asian ☐ Other ☐ White ☐ African-American

Vaccination Information

*** H1N1 Vaccine Lot #** _____ **VIS Provided** ☐ Yes ☐ No

*** Site/Route of vaccination (check):**

☐ Right Arm/Intramuscular ☐ Left Arm/Intramuscular ☐ Right Thigh/Intramuscular ☐ Left Thigh/Intramuscular ☐ Intranasal

* Vaccinator: _____ (**PRINT NAME**) * _____ (**SIGNATURE**) * _____ (**DATE OF SERVICE**)

Please fax this form to (505) 476-3585