

ARE YOU ELIGIBLE FOR THE H1N1 09 FLU VACCINE?

Name: Date of Birth:

Please tick the boxes that apply to you and hand this to your practice staff.

ARE YOU:

- | | | | |
|------------------------|--|--|--|
| ▪ Pregnant | <input type="checkbox"/> Yes <input type="checkbox"/> No | ▪ A Health & Community Care Worker
<i>(including volunteers and students)</i> | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| ▪ An Indigenous Person | <input type="checkbox"/> Yes <input type="checkbox"/> No | ▪ A parent or guardian of
children aged 0-6months | <input type="checkbox"/> Yes <input type="checkbox"/> No |

DO YOU HAVE:

- | | | | |
|----------------------------------|--|-------------------------|--|
| ▪ Chronic Respiratory Conditions | <input type="checkbox"/> Yes <input type="checkbox"/> No | ▪ Immunosuppression | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| ▪ Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | ▪ Diabetes Mellitus | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| ▪ Cardiac Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | ▪ Chronic Renal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| ▪ Chronic Metabolic Diseases | <input type="checkbox"/> Yes <input type="checkbox"/> No | ▪ Haemoglobinopathies | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| ▪ Chronic Neurological Diseases | <input type="checkbox"/> Yes <input type="checkbox"/> No | ▪ BMI greater than 35 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
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