

2009 H1N1 Influenza Vaccine Consent Form

Section 1: Information about Child to Receive Vaccine (please print)

STUDENT'S NAME:			STUDENT'S DATE OF BIRTH:	
(Last)	(First)	(M.I.)	Month _____	Day _____
PARENT/LEGAL GUARDIAN'S NAME:			STUDENT'S AGE:	STUDENT'S GENDER:
(Last)	(First)	(M.I.)	_____ Years	M / F
ADDRESS:			PARENT/GUARDIAN DAYTIME PHONE NUMBER:	
CITY:	STATE	ZIP	() -	
			Area Code	
SCHOOL NAME:		GRADE:	TEACHER:	

Section 2: Screening for Vaccine Eligibility

If your child has already been vaccinated with 2009 H1N1 influenza vaccine, please tell us the number of doses and dates of vaccination.

- | | | | | |
|---------------------------------|---|-----------------------|-------------|------|
| <input type="checkbox"/> Dose 1 | Date received: month _____ day _____ year _____ | Form (please circle): | nasal spray | shot |
| <input type="checkbox"/> Dose 2 | Date received: month _____ day _____ year _____ | Form (please circle): | nasal spray | shot |

The following questions will help us to know if your child can get the 2009 H1N1 influenza vaccine. Please mark YES or NO for each question.

A. If you answer "NO" to all four of the following questions, your child can probably get the influenza vaccine. If you answer "YES" to one or more of the following four questions, your child may be able to get the 2009 H1N1 vaccine, but we will contact you to discuss your options.

	YES	NO
1. Does your child have a serious allergy to eggs?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your child have any other serious allergies? Please list: _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Has your child ever had a serious reaction to a previous dose of flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>

B. There are two kinds of 2009 H1N1 influenza vaccine, the flu mist and the flu shot. Your answers to the following questions will help us know which of the two kinds of vaccine your child can get.

	YES	NO
1. Has your child been vaccinated with any vaccine (not just flu) within the past 30 days? Vaccine: _____ Date given: Month _____ Day _____ Year _____	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your child have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood?	<input type="checkbox"/>	<input type="checkbox"/>
3. Is your child on long-term aspirin or aspirin-containing therapy (for example, does your child take aspirin every day as a regular medication)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Does your child have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Is your child pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does your child have close contact with a person who needs care in a protected environment (for example, a family member or someone in the home who has recently had a bone marrow transplant)?	<input type="checkbox"/>	<input type="checkbox"/>

Section 3: Consent: If this consent form is not signed, dated, and returned, then your child will not be vaccinated at school

<p>CONSENT FOR CHILD'S VACCINATION: I have read or had explained to me the 2009-2010 Vaccine Information Statement for the 2009 H1N1 influenza vaccine and understand the risks and benefits.</p>	
<p>I <u>GIVE</u> CONSENT to the Metro Public Health Dept. and its staff for my child named at the top of this form to be vaccinated with this vaccine.</p> <p>Signature of Parent/Legal Guardian _____ Date: Month _____ Day _____ Year _____</p>	<p>I <u>DO NOT GIVE</u> CONSENT to the Metro Public Health Dept. and its staff for my child named at the top of this form to be vaccinated with this</p> <p>Signature of Parent/Legal Guardian _____ Date: Month _____ Day _____ Year _____</p>

Section 4: Vaccination Record

FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Dose Administered	Route	Dose Number (1st or 2nd)	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				