

2009 H1N1 Influenza Vaccine Consent Form for Schools

SECTION A: STUDENT INFORMATION

Name (Last, First, Middle Initial)	Date of Birth: Month _____ Day _____ Year _____	
School Name	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Grade

SECTION B: PARENT/GUARDIAN INFORMATION

Name (Last, First, Middle Initial):		
Address:	City/State:	Zip Code:
Phone Number(s) Home:	Work:	Cell:

SECTION C: SCREENING FOR VACCINE ELIGIBILITY

Has your child already received the **2009 H1N1 influenza** vaccine?

NO

YES, Dose 1 -Date received: Month _____ Day _____ Year _____ Nasal Spray Shot (Injection)

Children 9 years of age and younger should receive 2 vaccines, approximately one month apart to be protected.

SECTION D: STUDENT HEALTH HISTORY

Please mark YES or NO for <u>ALL</u> questions.	YES	NO	
Has your child received any one of the following vaccines within the past 30 days? <ul style="list-style-type: none"> • Measles/Mumps/ Rubella (MMR) • Varicella • Seasonal Influenza nasal spray (NOT the flu shot) 			If YES to any of these questions, student is not eligible for the nasal spray.
Does your child have an illness such as chronic heart disease, lung disease (such as asthma), kidney disease, liver disease, muscle or nerve disease (such as seizures), diabetes (blood sugar problems), blood disease (such as sickle cell anemia)?			
Does your child visit anyone who requires care in a protected environment (e.g., in isolation at a hospital)?			
Is your child pregnant?			
Has your child ever had a serious reaction to a previous dose of flu vaccine (shot or nasal spray), e.g., hives, difficulty breathing?			If YES to any of these questions, student is not eligible for the nasal spray or the shot.
Is your child receiving long-term aspirin therapy (e.g., do they take aspirin every day)?			
Is your child taking any prescription medication to prevent or treat flu?			
Does your child have a severe allergy to eggs?			
Does your child have any other severe allergies (a severe allergic reaction does NOT include symptoms such as upset stomach and diarrhea)? * Please list:			
Has your child ever had Guillain-Barré Syndrome (GBS)?*			

***Please note: The history or presence of a severe allergy or GBS may exclude your child from getting the H1N1 vaccine. A vaccine provider will determine your child's eligibility to be vaccinated.**

CONSENT FOR CHILD'S VACCINATION:

I have read the 2009-2010 Vaccine Information Statement for the 2009 H1N1 influenza shot and/or for the nasal spray. I understand the risks and benefits.

If you have questions about the vaccine, please contact XXXXXX at XXX-XXXX

I GIVE CONSENT for my child (named at the top of this form) to be vaccinated with the following type of 2009 H1N1 influenza vaccine.

- Nasal Spray or Flu Shot Only Nasal Spray Only Flu Shot

I understand that if I choose "only nasal spray" or "only flu shot," my child may not receive the 2009 H1N1 vaccine if that vaccine type is not available when the vaccination clinic is held or contraindications exist for the administration of the specified type of vaccine.

I understand that if my child is 9 years of age or younger, two doses of H1N1 influenza vaccine are needed. I CONSENT to two doses of the H1N1 flu vaccine for my child (named at the top of this form).

I understand that I may withdraw this consent at any time by (INCLUDE A WAY TO WITHDRAW CONSENT).

Signature of Parent/Legal Guardian _____

Date: Month _____ Day _____ Year _____

FOR ADMINISTRATIVE USE ONLY (To be completed by the medical provider)

Vaccine	Date Dose Administered	Route	Dose Number (1st or 2nd)	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator
2009 H1N1	/ /	IM Intranasal				
2009 H1N1	/ /	IM Intranasal				