

2009 H1N1 Influenza Vaccine Parent Consent for Child Vaccination

Section 1: Please Print

CHILD'S NAME (Last)		(First)	(M.I.)	CHILD'S DATE OF BIRTH month _____ day _____ year _____	
PARENT/LEGAL GUARDIAN'S NAME (Last)		(First)	(M.I.)	CHILD'S AGE	CHILD'S GENDER (circle) M / F
ADDRESS			PARENT/GUARDIAN <u>DAYTIME</u> PHONE NUMBER(S):		
CITY	STATE	ZIP	COUNTY		
CLINIC SITE					

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.

- Dose 1 Date received: month _____ day _____ year _____ (please circle one): nasal spray shot
- Dose 2 Date received: month _____ day _____ year _____ (please circle one): 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?		
2. Does your child have any other serious allergies? Please list: _____		
3. Has your child ever had a serious reaction to a previous dose of flu vaccine?		
4. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks of receiving flu vaccine?		

B. There are two types of 2009 H1N1 influenza vaccine. Your answers to the following questions will help us know which type your child can get.

	YES	NO
1. Has your child been given any vaccines, including any flu vaccine within the past 30 days? Vaccine: _____ Date given: month _____ day _____ year _____		
2. Does your child have any of the following: recurrent wheezing, asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood?		
3. Is your child on long-term aspirin or aspirin-containing therapy (for example, does your child take aspirin every day)?		
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)?		
5. Is your child pregnant?		
6. Does your child have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?		
7. Has your child taken any influenza antiviral medications in the last week (ex: Tamiflu, Relenza)? When?		

Section 3: Consent for Child's Vaccination:

I have read or had explained to me the Vaccine Information Statement for the 2009 H1N1 influenza vaccine and understand the risks and benefits.

I GIVE CONSENT to Public Health, Delta & Menominee Counties and its staff for my child (named above) to be vaccinated with the H1N1 vaccine.

*(If this consent form is not signed, dated, and returned, your child will **not** be vaccinated at school.)*

Signature of Parent / Legal Guardian

Date: month _____ day _____ year _____

I DO NOT GIVE CONSENT to Public Health, Delta & Menominee Counties and its staff to vaccinate my child (named above) with the H1N1 vaccine.

Signature of Parent / Legal Guardian

Date: month _____ day _____ year _____

FOR ADMINISTRATIVE USE ONLY

Vaccination Record

Vaccine	Date Administered and VIS Given	Site	Route	Dose Number (1 st or 2 nd)	Vaccine Manufacturer	Lot Number	Date of VIS	Name and title of Vaccine Administrator
2009 H1N1	/ /	<input type="checkbox"/> IM <input type="checkbox"/> Intranasal	<input type="checkbox"/> Rt Arm <input type="checkbox"/> Lt Arm <input type="checkbox"/> Rt Leg <input type="checkbox"/> Lt Leg <input type="checkbox"/> By Nose				10/2/09	
2009 H1N1	/ /	<input type="checkbox"/> IM <input type="checkbox"/> Intranasal	<input type="checkbox"/> Rt Arm <input type="checkbox"/> Lt Arm <input type="checkbox"/> Rt Leg <input type="checkbox"/> Lt Leg <input type="checkbox"/> By Nose				10/2/09	