

2009 H1N1 Influenza Vaccine Consent Form

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

STUDENT'S NAME (Last)		(First)	(M.I.)	STUDENT'S DATE OF BIRTH	
PARENT/LEGAL GUARDIAN'S NAME (Last)		(First)	(M.I.)	month _____ day _____ year _____	STUDENT'S AGE _____
ADDRESS		PARENT/GUARDIAN DAYTIME PHONE NUMBER: _____			
CITY	STATE	ZIP			
SCHOOL NAME			GRADE		

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 ____ Form (please circle): nasal spray shot
- Dose 2 Date received: month ___ day ___ year ____ Form (please circle): nasal spray shot

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

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"/>
1. Does your child have any other serious allergies that you know of? 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"/>

Section 3: Consent

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.

I GIVE CONSENT to the Grant County health department and its staff for my child named at the top of this form to get vaccinated with this vaccine. (If this consent form is not signed, dated, and returned, then you child will not be vaccinated at school.)

Signature of Parent/Legal Guardian _____
Date: month ___ day ___ year ____

I DO NOT GIVE CONSENT to the Grant County health department and its staff for my child named at the top of this form to get vaccinated with this vaccine.

Signature of Parent/Legal Guardian _____
Date: month ___ day ___ year ____

Section 4: Permission to Release Information

Placeholder for parental consent for release of data from vaccination record.

Section 5: 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	/ /	IM				
2009 H1N1	/ /	IM				