

## Warren County Health Department 2009/2010 H1N1 Child Influenza Vaccine Consent Form

Please read carefully and complete all sections. If there is anything you do not understand, be sure to ask. If giving consent, be sure to sign in TWO places.

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

STUDENT'S NAME (Last)		(First)	(M.I.)	STUDENT'S DATE OF BIRTH	
				month	day
				year	
PARENT/LEGAL GUARDIAN'S NAME (Last)		(First)	(M.I.)	STUDENT'S AGE	STUDENT'S GENDER
					M / F
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 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 after receiving a flu vaccine?		

**B. There are two kinds of 2009 H1N1 influenza vaccine. Your answers to the following questions will help us know which of the two kinds of vaccine your child can get. CIRCLE THE TYPE OF VACCINE YOU WANT YOUR CHILD TO RECEIVE: NASAL SPRAY or SHOT**

	YES	NO
1. Has your child gotten vaccinated with any vaccine (not just flu) within the past 30 days? Vaccine: _____ Date given: month ___ day ___ year _____		
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?		
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)?		

**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.

<p>I GIVE CONSENT to the Warren County Health Department and its staff for my child named at the top of this form to be vaccinated with this vaccine.</p> <p>(If this consent form is not signed, dated, and returned, then your child will not be vaccinated at school)</p> <p>Signature of Parent/Legal Guardian _____ Date: month ___ day ___ year _____</p>	<p>I DO NOT GIVE CONSENT to the Warren County Health Department 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>
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**Section 4: Permission to Release Information**

I authorize the Warren County Health Department to release data from this vaccination form for the purpose of data collection and tracking doses.

(Child's Physician)	(Signature of Parent/Legal Guardian)	(Date)
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I want to be present for the immunization

I do not need to be present for the immunization

**Section 5: Vaccination Record**

FOR ADMINISTRATIVE USE ONLY

**Name of Person to be Vaccinated:**

**DOB:**

<b>Vaccine</b>	<b>Date Dose Administered</b>	<b>Route</b>	<b>Dose Number (1st or 2nd)</b>	<b>Vaccine Manufacturer</b>	<b>Lot Number</b>	<b>Exp. Date</b>	<b>Name and Title of Vaccine Administrator</b>
2009 H1N1		Intranasal	0.2mL	Medimmune	500762P	25Jan2010	
2009 H1N1		Intranasal					
2009 H1N1		IM					
2009 H1N1		IM					