District Health Department No. 4
2009 H1N1 Influenza Vaccine Consent Form

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

STUDENT'S NAME (Last)	(First)	(M.I.)	**DATE OF BIRTH**		
ADDRESS	**CITY**	**STATE**	**ZIP**	**AGE**	**MALE FEMALE**
SCHOOL					**GRADE**
PARENT/LEGAL GUARDIAN'S NAME (Last)	(First)				
PARENT/LEGAL GUARDIAN'S DAYTIME PHONE NUMBER	**( )**				
PARENT/LEGAL GUARDIAN'S E-MAIL ADDRESS					

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.

	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?		

I would like my child to receive: please circle FluMist Injectable Shot

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. Medical Staff will evaluate and make a determination if the FluMist is appropriate.

	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

CONSENT FOR CHILD'S VACCINATION: **YES NO**

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 the District Health Department No. 4 and its staff for my child named at the top of this form to be vaccinated with this vaccine. (If this consent form is not signed, dated, and returned, then your child will not be vaccinated at school)	I **DO NOT GIVE CONSENT** to the District Health Department No. 4 and its staff for my child named at the top of this form to be vaccinated with this vaccine, at this time.
Signature of Parent/Legal Guardian _____	Signature of Parent/Legal Guardian_____
Date: month_____day_____year_____	Date: month_____day_____year_____

FOR ADMINISTRATIVE USE ONLY

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