

SCHOOL-BASED 2009 H1N1 INFLUENZA VACCINE CONSENT FORM

Student's Name (First): _____ (Middle): _____ (Last): _____

Date of Birth: _____ Gender: M or F Age: _____

Mailing Address: _____ Zip Code _____

City: _____ State: _____ Phone Number: _____

Parent/Legal Guardian's Name: _____ Mother's Maiden Name: _____

School Name: _____ Grade: _____

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.

	Yes	No
Does your child have a serious allergy to eggs?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child have any other serious allergies? Please list: _____	<input type="checkbox"/>	<input type="checkbox"/>
Has your child ever had a serious reaction to a previous dose of flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
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"/>

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.

	Yes	No
Has your child received any other vaccinations in the past 4 weeks? Vaccine: _____ Date given: month _____ day _____	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
Is your child on long-term aspirin or aspirin-containing therapy (for example, does your child take aspirin every day)?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)?	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input type="checkbox"/>	<input type="checkbox"/>
Is your child pregnant or could she become pregnant within the next month?	<input type="checkbox"/>	<input type="checkbox"/>

IRIS: I give permission to enroll me or my child and to transfer my or my child's immunization records into the Idaho Immunizations Reminder Information System (IRIS) to ensure that this vaccination record is available to me, my or my child's health care providers and schools. I understand I may be asked for information that will help ensure my or my child's records are accurate and will not be confused with another person's records, such as: mother's maiden name, telephone number, child's gender, and child's eligibility for free vaccine.

I authorize inclusion of all information into IRIS. _____ NO (do not enroll me/my child in IRIS)

Signature _____ Date _____

CONSENT

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 Central District Health Department 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)

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

I DO NOT GIVE CONSENT to Central District Health Department and its staff for my child named at the top of this form to be vaccinated with this vaccine.

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

For Official Use Only

Flu Manufacturer: Sanofi Aventis GSK MedImmune Lot#: _____

Dose: 0.25 ml 0.5 ml

Inject Site: Lt Rt deltoid thigh Other: _____

Nasal Spray Lot#: _____

Date Given: _____ Signature of Administrator: _____