

# CHILD - 2009 H1N1 Influenza Vaccine Consent Form

## Section 1: Information about Child to Receive Vaccine (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 M / F
ADDRESS			CHILD'S MOTHER'S MAIDEN NAME:	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 seasonal and/or 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                  seasonal                  H1N1
- Dose 2      Date received: month \_\_\_ day \_\_\_ year \_\_\_\_      Form (please circle):    nasal spray                  shot                  seasonal                  H1N1

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"/>
2. Does your child have any other serious allergies that you know of? Please list: _____		
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"/>

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

	YES	NO
1. Has your child gotten vaccinated with any vaccine (not just flu) within the last 30 days? Vaccine: _____ Date given: month _____ day _____ year _____	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input type="checkbox"/>	<input type="checkbox"/>
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.

**I GIVE CONSENT to the Southeastern District Health Department, its staff, and volunteers for my child named at the top of this form to get vaccinated.**

Signature of Parent/Legal Guardian \_\_\_\_\_ Date: month \_\_\_\_\_ day \_\_\_\_\_ year \_\_\_\_\_

### CONSENT FOR IDAHO IMMUNIZATION REMINDER INFORMATION SYSTEM:

I also give permission to enroll me or my child and to transfer my or my child's immunization records into the Idaho Immunization Reminder Information System (IRIS) to ensure this vaccination record is available to me, my or my child's healthcare providers, childcare providers, and schools. I understand I may be asked for information that will 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, gender, and child's eligibility for free vaccine. I authorize inclusion of all information into IRIS and redisclosure of this information from IRIS to authorized users.

Signature \_\_\_\_\_ Date: month \_\_\_\_\_ day \_\_\_\_\_ year \_\_\_\_\_

**Section 5: Vaccination Record**

**FOR ADMINISTRATIVE USE ONLY**

<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>Name and Title of Vaccine Administrator</b>
2009 H1N1	/ /	IM or FluMist				
2009 H1N1	/ /	IM or FluMist				