

## 2009 H1N1 Influenza Vaccine Consent Form

STUDENT'S NAME (Last)	(First)	(M.I.)	DATE OF BIRTH	AGE	GENDER M / F
ADDRESS	CITY	STATE	ZIP CODE	PHONE	
PARENT/GUARDIAN NAME (Last)	(First)	DAYTIME PHONE			
SCHOOL NAME:			GRADE:		
CHILD'S PEDIATRICIAN/PHYSICIAN:			PHONE:		

**The following questions will help us to determine if your child can receive the H1N1 Influenza Vaccine.  
Please answer ALL questions below for your child.**

If you answer "NO" to all four of the following questions, your child can get the influenza vaccine. If you answer "YES" to one or more of the following four questions, your child will not be able to receive the H1N1 vaccination at school. Please consult your family physician.

	YES	NO
1. Is your child ill today?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your child have a serious allergy to eggs, latex, gentamicin, gelatin, arginine, neomycin, polymixin or thimerisol?	<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) after receiving a flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>

Please list any allergies:

**The following questions will determine which type of 2009 H1N1 Influenza Vaccine your child can receive.  
Please answer ALL questions below for your child.**

If you answer "NO" to all of the following six questions, your child may receive either the 2009 H1N1 Influenza nasal spray (live virus) vaccine or the 2009 H1N1 Influenza "flu shot" (inactivated virus). If you answer "YES" to any of the following six questions, your child can only receive the 2009 H1N1 Influenza "flu shot" (inactivated virus) vaccine.

	YES	NO
1. Has your child been vaccinated with <b>any</b> vaccine within the past 30 days?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your child have any of the following: asthma or episodes of wheezing, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, muscles or nerves (such as cerebral palsy), or blood?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does your child have close contact with a person with a severely weakened immune system who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?	<input type="checkbox"/>	<input type="checkbox"/>

**Please read and check one of the following three boxes. Sign and date the form.**

**Consent for Administration of 2009 H1N1 Influenza Vaccine for the above-named recipient:**

I understand that my child will not receive the vaccine if he/she is uncooperative. I have received and read the Vaccine Information Statements (VIS 2009 H1N1 Inactivated Influenza Vaccine 10/2/09, 2009 H1N1 LAIV 10/2/09) and the Notice of Privacy Practices. I have had the opportunity to ask questions regarding the vaccine and understand the risks and benefits, and acknowledge the Clermont County Board of Health is not responsible or liable for any vaccine reaction that may occur. I request and voluntarily consent that the vaccine be given to the person above for whom I am parent or legal guardian and acknowledge no guarantees have been made concerning the vaccine's success. I give Clermont County General Health District permission to release the medical records of the above-named person to the family doctor, school/employer and the Ohio Department of Health Immunization Registry.

- My child may receive either the 2009 H1N1 Influenza nasal spray (live virus) vaccine OR the 2009 H1N1 Influenza "flu shot" (inactivated virus) vaccine.
- My child may only be given the 2009 H1N1 Influenza nasal spray (live virus) vaccine. I understand that if the 2009 H1N1 Influenza nasal spray (live virus) vaccine is not available, or my child is not eligible based upon the screening questions, my child will not be vaccinated.
- My child may only be given the 2009 H1N1 Influenza "flu shot" (inactivated virus) vaccine.

Signature of Parent/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

\*\*\*\*\*FOR ADMINISTRATIVE USE ONLY\*\*\*\*\*

Vaccine	Date Dose Administered	Lot Number	Vaccine Manufacturer	Site of Injection	Route	Name and Title of Vaccine Administrator
2009 H1N1				<input type="checkbox"/> RD <input type="checkbox"/> LD <input type="checkbox"/> RT <input type="checkbox"/> LT	<input type="checkbox"/> IM <input type="checkbox"/> Intranasal	

