

## Warren County Combined Health District 2009 H1N1 Influenza Vaccine Consent Form

**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 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"/>
1. Does your child have any other serious allergies that you know of? Please list: _____	<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) within 6 weeks after receiving a flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>

**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 Warren County Health Department and its staff for my child named at the top of this form to get vaccinated (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 \_\_\_\_\_

**Section 4: Vaccination Record**

**FOR ADMINISTRATIVE USE ONLY**

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