

## 2009-2010 H1N1 Influenza Vaccine Consent Form

Please fill out if receiving H1N1 vaccine during a School Based Clinic

|   |       |                 |                                       |             |                                |
|---|-------|-----------------|---------------------------------------|-------------|--------------------------------|
| NAME (Last)                                       |       | (First)         | (M.I.)                                | SCHOOL NAME |                                |
| DATE OF BIRTH<br>month _____ day _____ year _____ |       | GENDER<br>M / F |                                       | AGE         | STUDENT'S AGE      GRADE/CLASS |
| ADDRESS   |       |                 | PARENT/LEGAL GUARDIAN'S NAME          |             |                                |
| CITY  | STATE | ZIP             |                                       |             |                                |
| PHONE NUMBER                                      |       |                 | PARENT/GUARDIAN DAYTIME PHONE NUMBER: |             |                                |

**The following questions will help us to know if you or your child can get the 2009 H1N1 influenza vaccine.  
Please mark YES or NO for each question.**

|  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| Does your child/self have a severe allergy or reaction to any shots or medication?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Does your child/self have an allergy to eggs, gentamicin, arginine, streptomycin, neomycin, polymixin B, thimerosal, gelatin, or latex? (explain)                        | <input type="checkbox"/> | <input type="checkbox"/> |
| Has your child/self ever had a serious reaction to a previous dose of flu vaccine?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Has your child/self 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"/> |
| Has your child/self been vaccinated with any vaccine (not just flu) within the past 30 days?<br>Vaccine: _____ Date given: month _____ day _____ year _____              | <input type="checkbox"/> | <input type="checkbox"/> |
| Does your child/self 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/self 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/self 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"/> |
| Is your child/self pregnant?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Does your child/self 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"/> |

### CONSENT FOR VACCINATION:

By signing this form I acknowledge that 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 also acknowledge that I have had the opportunity to view a copy of the Health Departments Notice of Privacy Practices Summary which explains the policies concerning me or my child's personal health information at [www.starkhealth.org](http://www.starkhealth.org).

I GIVE CONSENT to the STATE/LOCAL health department and its staff for me or the 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 you or your child will not be vaccinated)**

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

#### FOR ADMINISTRATIVE USE ONLY

| Vaccine   | Date Dose Administered | Route  | SITE  | Vaccine Manufacturer | Lot Number | Name and Title of Vaccine Administrator |
|-----------|------------------------|--|-------|----------------------|------------|---|
| 2009 H1N1 | / /                    | <input type="checkbox"/> IM<br><input type="checkbox"/> Intranasal | LD RD |                      |            |   |