

2009 H1N1 Influenza Vaccine Consent Form

SECTION A: STUDENT INFORMATION

Name : _____

Grade: _____

Date of Birth: Month _____ Day _____ Year _____

Gender: Male Female

SECTION B: SCREENING FOR VACCINE ELIGIBILITY

Has your child already received the 2009 H1N1 influenza vaccine?

NO

YES, Date received: Month _____ Day _____ Year _____

SECTION C: STUDENT HEALTH HISTORY

Please mark YES or NO for ALL questions.

	YES	NO
Has your child received any one of the following vaccines within the past 30 days? * Measles/Mumps/Rubella (MMR) * Varicella		
Does your child have an illness such as chronic heart disease, lung disease (e.g. asthma), kidney disease, liver disease, muscle or nerve disease (e.g. seizures), diabetes, blood disease (e.g. sickle cell anemia)?		
Does your child visit anyone who requires care in a protected environment (e.g. in isolation at a hospital)?		
Has your child ever had a serious reaction to a previous dose of flu vaccine (e.g. hives, difficulty breathing)?		
Is your child receiving long-term aspirin therapy (e.g., do they take aspirin every day)?		
Is your child taking any prescription medication to prevent or treat flu?		
Does your child have allergy to eggs?		
Does your child have any other severe allergies (a severe allergic reaction does NOT include symptoms such as upset stomach and diarrhea)?		
Has your child ever had Guillain-Barre Syndrome (GBS)?		

CONSENT FOR CHILD'S VACCINATION:

I have read the 2009 Vaccine Information Statement for the 2009 H1N1 influenza shot.
I understand the risks and benefits.

If you have questions about the vaccine, please contact Ms. Aveegayle the school nurse, at 392-1088 ext. 106.

I GIVE PERMISSION that my child (full name) _____

Receive the H1N1 Influenza vaccine.

Does **not** receive the H1N1 Influenza vaccine.

Parent's Signature

Date