



## 2009 H1N1 Influenza Vaccine Consent Form

**STUDENT**

### 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		
Medicare #			Medicaid #		

### 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 to know if the person being immunized can get the 2009 H1N1 influenza vaccine.

Please mark Yes or No for each question.

	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? 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 of receiving flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>

There are two types of 2009 H1N1 influenza vaccine. Your answers to the following questions will help us know which type your child can get.

	YES	NO
1. Has your child been given any vaccines, including any flu vaccine within the past 30 days? <b>Vaccine:</b> _____ <b>Date given:</b> month ___ day ___ year _____	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your child have any of the following: recurrent wheezing, 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"/>
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 who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?	<input type="checkbox"/>	<input type="checkbox"/>
7. Has your child taken any influenza antiviral medications in the last week (ex. Tamiflu, Relenza)? If yes, when?	<input type="checkbox"/>	<input type="checkbox"/>
8. I authorize Washtenaw County Public Health Department to release this immunization record to the Michigan Care Improvement Registry, appropriate daycare, school personnel, employer or the healthcare provider(s) as needed	<input type="checkbox"/>	<input type="checkbox"/>

### Section 3: Consent

<p>I GIVE CONSENT to the STATE/LOCAL health department and its staff for my child named at the top of this form to be vaccinated with this vaccine.</p> <p>Signature: _____</p> <p>Date: month _____ day _____ year _____</p>	<p><b>CONSENT FOR VACCINATION:</b> I have read or had explained to me the Vaccine Information Statement for the 2009 H1N1 influenza vaccine and understand the risks and benefits</p> <p><b>TYPE OF VACCINE REQUESTED:</b></p> <p>Nasal <input type="checkbox"/>          Injectable <input type="checkbox"/>          No Preference <input type="checkbox"/></p>
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