

2009 H1N1 Influenza Vaccine Consent Form -Children

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 Male Female |
| ADDRESS | | | PARENT/GUARDIAN DAYTIME PHONE NUMBER: | | |
| CITY | STATE | ZIP | Home or Work: () Cell: () | | |
| SCHOOL NAME | | CLINIC LOCATION | | GRADE | TEACHER NAME |

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 five of the following questions, your child can probably get the influenza vaccine. If you answer "**YES**" to one or more of the following five 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"/> |
| 2. Does your child have serious allergies to neomycin, gentamicin, thimerosal, gelatin or arginine or polymyxin B sulfate? 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"/> |
| 5. Is your child receiving aspirin or aspirin-containing therapy? | <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 understand that the vaccine may contain thimerosal.

I GIVE CONSENT to the Vermont Department of Health, and staff working on its behalf, to vaccinate my child named at the top of this form with the H1N1 vaccine. (If this consent form is not signed, dated and returned to your child's school, then your child will not be vaccinated at school).

Signature of parent/legal guardian: _____
Date: month _____ day _____ year _____

I DO NOT GIVE CONSENT to the Vermont Department of Health, and staff working on its behalf, to vaccinate my child named at the top of this form with the H1N1 vaccine.

Signature of parent/legal guardian _____
Date: month _____ day _____ year _____

Section 4: Vaccination Record

FOR ADMINISTRATIVE USE ONLY

| Vaccine | Date Dose Administered | Route | Dose Number | Body Site | Lot Number | Manufacturer | Date VIS given | Name and Title of Vaccine Administrator |
|-----------|------------------------|-------|------------------------------|--|------------|--------------|----------------|---|
| 2009 H1N1 | / / | IM | <input type="checkbox"/> 1st | <input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> RT <input type="checkbox"/> LT | | | | |
| 2009 H1N1 | / / | IM | <input type="checkbox"/> 2d | <input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> RT <input type="checkbox"/> LT | | | | |

Please return this form to school whether or not you want your child to be vaccinated.