

2009 H1N1 Influenza Vaccine School-Based Clinic Consent Form

Section 1: Consent for Child's Vaccination

IF YOU DO NOT COMPLETE THIS FORM AND RETURN IT TO SCHOOL, YOUR CHILD WILL NOT BE VACCINATED.

I GIVE CONSENT to the Columbia/Boone County Dept of Public Health and Human Services and its staff for my child named on this form to be vaccinated with the 2009 H1N1 influenza vaccine. I have read or had explained to me the 2009-2010 Vaccine Information Statement (10/2/09 version) for the 2009 H1N1 influenza vaccine and understand the risks and benefits.

Signature of Parent/Legal Guardian _____ Date: month _____ day _____ year _____

Check here if you want to be present when your child receives the vaccination.

Section 2: 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		DOES YOUR CHILD LIVE INSIDE THE CITY LIMITS OF COLUMBIA? <input type="checkbox"/> Yes <input type="checkbox"/> No		
SCHOOL NAME					GRADE/TEACHER (if applicable)	

Section 3: 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 your child can get the 2009 H1N1 influenza vaccine. Please mark YES or NO for each question.

A. 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"/>
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 after receiving a flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>

B. There are two different ways we can give the 2009 H1N1 influenza vaccine (shot and nasal spray). Your answers to the following questions will help us determine which way your child can receive the vaccine.

	YES	NO
1. Has your child been vaccinated with any vaccine (including seasonal flu) within the past 30 days? Vaccine: _____ Date given: month _____ day _____ year _____	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your child 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"/>
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"/>

Section 4: Permission to Release Information

Check here if you do **NOT** want this information entered into Missouri's immunization registry.

FOR ADMINISTRATIVE USE ONLY - Section 5: Vaccination Record - FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Dose Administered	Route	Dosage	VIS Given	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator
2009 H1N1 Dose #1	/ /	<input type="checkbox"/> IM R L <input type="checkbox"/> Intranasal	<input type="checkbox"/> 0.25 cc <input type="checkbox"/> 0.5 cc <input type="checkbox"/> 0.2 cc	<input type="checkbox"/> MIV 10/2/09 <input type="checkbox"/> LAIV 10/2/09			
2009 H1N1 Dose #2	/ /	<input type="checkbox"/> IM R L <input type="checkbox"/> Intranasal	<input type="checkbox"/> 0.25 cc <input type="checkbox"/> 0.5 cc <input type="checkbox"/> 0.2 cc	<input type="checkbox"/> MIV 10/2/09 <input type="checkbox"/> LAIV 10/2/09			