

2009 H1N1 Influenza Vaccine Consent Form

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	Student SS #	Student ID#	
SCHOOL NAME			GRADE	TEACHER	

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 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 only through your private provider.

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

	YES	NO
1. Has your child gotten vaccinated with any vaccine (not just 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 3: Consent

CONSENT FOR CHILD'S VACCINATION: I give permission for my child to receive: Intranasal H1N1 Vaccine Injectable vaccine Either

I have received, read, and understand the Novel H1N1 Vaccine Information Statement (VIS). I have had a chance to ask questions and discuss my concerns with a healthcare professional. I give permission to the Collier County Health Department to give my child the H1N1 vaccine marked above in my absence.

I _____, (please print name of consenting adult), have the following relation: with the child named above (please check relationship to child).

- Court Order Legal Guardian Father Mother Adult Aunt Adult Uncle Adult Brother Adult Sister
- Grandmother Grandfather Stepmother Stepfather

I have the legal authority, based on the relationship to the child as indicated above pursuant to s.743.0645, F.S., to consent to this administration for the child named above.

Print Name _____

Signature of Parent/Legal Guardian _____ Date _____

PLEASE COMPLETE THIS FORM IF YOU HAVE MEDICARE, MEDICAID OR PRIVATE INSURANCE

Insurance Company Name: _____

Insurance Telephone Number (____) _____

Insurance Address _____

City _____ **St** _____ **Zip** _____

Insurance Identification Number: _____ **Group Number:** _____

Name of Insured: _____

Date of Birth of Insured: Month _____ Day _____ Year _____

Relationship to Insured _____ **Self** _____ **Spouse** _____ **Child** _____ **Dependent**

I certify the information given by me is correct to the best of my ability. I authorize any holder of medical or other information about me to release the Social Security Administration or its intermediaries or carriers any information needed for this claim. I permit a copy of this authorization to be used in place of the original. I request that payment of authorized benefits be made on my behalf. I assigned the benefits payable for these services to the organization furnishing the service or authorize such physician or organization to submit a claim to Medicare for payment by me. I have also received a copy of the Notice of Privacy Practices.

Signature: _____ **Date** _____

Section 4: Vaccination Record
FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Dose Administered	Route	Site	Dose Number (1st or 2nd)	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator
2009 H1N1		<input type="checkbox"/> IM <input type="checkbox"/> Intranasal	<input type="checkbox"/> RDT <input type="checkbox"/> LDT				
2009 H1N1		<input type="checkbox"/> IM <input type="checkbox"/> Intranasal	<input type="checkbox"/> RDT <input type="checkbox"/> LDT				

VIS DATE: 10-2-09

Date VIS given: _____