

2009 H1N1 Influenza (Flu) Immunization Consent Form for Students

(PLEASE PRINT)

(Please return to the school)

Student's Last Name: _____ First: _____ Middle: _____
 Gender: (M / F) Date Of Birth: _____ Grade: _____ Room: _____
 Address: _____ City: _____
 Zip: _____ Phone: _____ email: _____

These questions will help determine if your child can get the H1N1 vaccine and what type (nasal or shot)

1. Does your child have allergies to medications, food or any vaccine? Yes No Don't Know
Please list any allergies: _____
2. Has your child ever had Guillain-Barré syndrome? Yes No Don't Know
3. Has your child ever received seasonal flu vaccination before? Yes No Don't Know
 If Yes, date received: _____ Type: nasal spray shot
4. Has your child ever received H1N1 Influenza vaccine Yes No Don't Know
 If Yes, date received: _____ Type: nasal spray shot
5. Has your child ever had a serious reaction to flu vaccine in the past? Yes No Don't Know
6. Has your child received any other vaccines in the past 4 weeks?..... Yes No Don't Know
 If yes, which one(s): _____ Date given: _____
7. Does your child have a health problem with asthma, lung disease, heart disease, kidney disease, metabolic disease (e.g. diabetes) or a blood disorder (e.g. sickle cell anemia?) Yes No Don't Know
8. Is your child on long-term aspirin therapy? Yes No Don't Know
9. Does your child have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long term treatment with drugs such as steroids, or cancer treatment with x-rays or drugs? Yes No Don't Know
10. Is your child pregnant or planning to become pregnant in the next month? Yes No Don't Know

I have been given a copy and have read, or have had explained to me, the information in the "Vaccine Information Statement" for H1N1 influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine. I understand that medical personnel will determine if my child receives a flu shot or nasal spray, whichever is medically indicated and available. I request that the influenza vaccine be given to the person above. I also request that the person listed above be given a second dose of flu vaccine, at a later time, and if recommended.

I agree to allow information on immunizations given to the person named above, to be released to other medical care providers to avoid unnecessary vaccination or to check immunization status. I will contact the CAIR-SDIR at (619) 692-5656 if I do not want to share the immunization record with other authorized organizations.

Signature of parent/guardian _____ **Date** _____

FOR CLINIC USE

SDIR entry completed <input type="checkbox"/>	Date Vaccinated _____ Vaccinator _____ Vaccine used: <input type="checkbox"/> nasal <input type="checkbox"/> shot Lot # _____ Site of Injection _____	2nd Dose if needed: Date Vaccinated _____ Vaccinator _____ Vaccine used: <input type="checkbox"/> nasal <input type="checkbox"/> shot Lot # _____ Site of Injection _____
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