

Jasper County Health Department 2009 H1N1 Influenza Vaccine Consent Form - *Child 18 Years & Younger*

Section 1: Information about Child to Receive Vaccine (please print)

NAME (Last)		(First)	(M.I.)	DATE OF BIRTH month _____ day _____ year _____	
ADDRESS				DAYTIME PHONE NUMBER:	
CITY	STATE	ZIP		MEDICAID NUMBER:	
PARENT'S NAME		PHYSICIAN		STUDENT'S AGE	STUDENT'S GENDER M / F
SCHOOL NAME (if Student)				GRADE	

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 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 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 have read or had explained to me the 2009-2010 Vaccine Information Statement for the 2009 H1N1 influenza vaccine and understand the risks / benefits.

I GIVE CONSENT to the Jasper County Health Department and its staff for my child named at the top of this form to be vaccinated with this vaccine.

Signature of Parent/Legal Guardian _____

Date: _____

Section 4: Permission to Release Information

My signature above gives Jasper County Health Department permission to release information to my child's physician about his/her vaccines.

Section 5: Vaccination Record

FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Dose Administered	Route	Dose Number (1st or 2nd)	Site	Vaccine Manufacturer	Lot Number	VIS Received _X_	Name and Title of Vaccine Administrator
2009 H1N1	/ /	<input type="checkbox"/> Intranasal			MedImmune LLC	500762P Exp. 1/25/10	Date: 10/2/09	
2009 H1N1	/ /	<input type="checkbox"/> IM			Sanofi Pasteur	UP022AA 4/15/11	Date 10/2/09	
2009 H1N1	/ /	<input type="checkbox"/> IM		1st	Novartis	100739 3 P 1 / 10	Date: 10/2/09	

Priority Group: _____ Children age 6 months through 24 years _____ Persons 25 – 64 Years with Health Condition

_____ Household contact / caregiver of infant less than 6 months of age _____ Healthcare & EMS Personnel _____ Pregnant Woman