

ST. MARY'S COUNTY HEALTH DEPARTMENT SCHOOL H1N1 FLU VACCINATION CONSENT FORM 2009-10

Last Name: _____ First Name: _____ MI: _____

Address: _____ Zip code: _____ Phone(w): _____

Phone(h): _____ Date of Birth: _____ Age: Sex: Race: Ethnicity: (Circle) *Hispanic/ Not-Hisp.*

School: _____ Teacher/Grade: _____ Middle/High School Student # _____

★ Please answer the following questions for

your child being vaccinated; check Yes or No, and CIRCLE condition or EXPLAIN in extra space. If your child is sick on influenza (flu) vaccination day with a fever, the vaccine cannot be given.

Medical History:

1. Did you child receive seasonal flu vaccine this year?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Has your child ever had a serious allergic reaction to flu vaccine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Does your child have a serious allergy to medications (esp. neomycin, gentamycin), food (esp. eggs, egg products, gelatin), vaccines, or other? Read the Vaccine Information Sheet about vaccine ingredients.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Does your child have a chronic health problem [such as heart disease, metabolic disease (like diabetes), kidneys or lungs (like asthma or cystic fibrosis), nervous system, seizures, the brain, or blood system (like sickle cell anemia)]?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. If your child is between 2 to 4 yrs. old, in the past 12 months, has a health care provider said that your child was wheezing or has asthma?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Does your child have cancer, leukemia, AIDS, or any other immune system problem, including the removal of the spleen?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Has your child taken cortisone, prednisone, other steroids, <u>nose sprays</u> , or anticancer drugs or x-ray treatments? When?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Is your child taking medicine containing aspirin? Drug/dose _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Has your child had Guillian-Barre syndrome?(a temporary ascending paralysis)	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Has your child received any vaccines in the past 4 weeks? Does your child have an appt. for any this month?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Does your child live with someone with a weakened immune system who has to be in a protective environment (a hospital room with reverse airflow)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Has your child had a blood transfusion or blood products, or immune (gamma) globulin? When?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. For females: Is the child pregnant or planning pregnancy in the next month?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Statement of Consent:

"I have read and understood the Vaccine Information Statement(s) (VIS) which I received. I have had the chance to ask any questions I had about the vaccine(s). I agree to have my medical information recorded electronically. I was offered a copy of the Notice of Privacy Practice with an effective date of 4/14/03."

Name of Child (print): _____ Relationship to Child: _____

Signature of Parent/Child if 18: _____ Date: _____

For Clinic/Office Use: Clinic Address/Date: SMCHD - _____

H1N1 Influenza Vaccine #1	Date Administered	By
H1N1 Nasal mist/MedImmune Lot # _____ <small>VIS /09</small>	Exp _____ <small>nasal</small>	H1N1 Injection/ Sanofi Pasteur Lot # Exp _____ <small>VIS /09</small> RA or LA IM
H1N1 Influenza Vaccine #2	Date Administered	By
H1N1 Nasal mist/MedImmune Lot # _____ <small>VIS /09</small>	Exp _____ <small>nasal</small>	H1N1 Injection/ Sanofi Pasteur Lot # Exp _____ <small>VIS /09</small> RA or LA IM