2009 H1N1 Influenza Vaccine Consent Form

Information about child to receive vaccine (please print)

Name: _____

LAST FIRST DATE OF BIRTH AGE

Address: _____

STREET CITY PARENT/GUARDIAN DAYTIME PHONE NUMBER

The following questions will help us know if your child can get the 2009 H1N1 influenza vaccine. Please mark YES or NO for each question.

	YES	NO
1. Does your child have a serious allergy to eggs?	☐	☐
2. Does your child have any other serious allergies that you know of? If yes, please list:	☐	☐
3. Has your child ever had a serious reaction to a previous dose of flu vaccine?	☐	☐
4. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	☐	☐
5. Has your child been vaccinated with any vaccine (not just flu) within the past 30 days? Vaccine_____ Date given:_____ (m/d/yr)	☐	☐
6. 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?	☐	☐
7. Is your child on long-term aspirin or aspirin-containing therapy (for example, does your child take aspirin every day)?	☐	☐
8. Does your child have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer), or is your child pregnant?	☐	☐

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 injection

☐ Dose 2 Date received: month ____day____year_____ Form (please circle): nasal spray injection

Consent for Child's Vaccination

I have read or have had explained to me the Vaccine Information Statement (VIS) on 2009 H1N1 Influenza Vaccine. I give my consent for my child, named at the top of this form to be vaccinated with this vaccine. I understand that if I sign below I am giving consent and my child will be given the most appropriate vaccine as determined by the health care provider giving the vaccine.

Signature of parent or legal guardian: _____Date: _____

CLINIC USE ONLY Dose: ☐ First ☐ Second ☐ Unknown

Age Categories: ☐ 6-23 mos ☐ 24-59 mos ☐ 5-18 yrs ☐ 19-24 yrs ☐ 25-49 yrs ☐ 50-64 yrs ☐ ≥ 65 yrs

2009 H1N1 VACCINE CHECK BOX	MANUFACTURER CIRCLE	LOT #/ EXP DATE FILL IN	DOSE CIRCLE	ROUTE CIRCLE	SITE CIRCLE	CDC VIS CIRCLE
☐ MULTI DOSE VIAL	SANOFI-PASTEUR NOVARTIS CSL		0.25ML 0.5ML	IM	RT LT	10/02/2009
☐ SINGLE DOSE SYRINGE, PEDIATRIC	SANOFI-PASTEUR		0.25 ML			
☐ SINGLE DOSE SYRINGE, ADULT	SANOFI-PASTEUR NOVARTIS CSL		0.5 ML		RD LD	
☐ SINGLE DOSE INTRANASAL SPRAYER	MEDIMMUNE		0.2 ML	INTRANASAL		

SIGNATURE OF VACCINE ADMINISTRATOR	DATE