

School Consent for 2009 H1N1 Influenza Injectable Vaccine

Section 1: Information about Child to Receive Vaccine (PLEASE PRINT CLEARLY)

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
STUDENT'S ADDRESS				STUDENT'S RACE (check all that apply)	
CITY		COUNTY		<input type="checkbox"/> American Indian / Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black / African American <input type="checkbox"/> Native Hawaiian / Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify) _____	
STATE	ZIP	SCHOOL NAME	GRADE		
PARENT / GUARDIAN DAYTIME PHONE NUMBER:				STUDENT'S ETHNICITY Hispanic or Latino: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Section 2: Screening for Vaccine Eligibility

If your child has already been vaccinated with **2009 H1N1 influenza vaccine** (NOT SEASONAL 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.

	YES	NO
1. Does your child have an allergy to eggs?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your child have any other allergies? Please list:	<input type="checkbox"/>	<input type="checkbox"/>
3. Has your child ever had a 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"/>

If you answered "NO" to all of the questions above, your child can probably get the 2009 H1N1 influenza vaccine. If you answered "YES" to one or more of the questions, you should contact your child's healthcare provider or your local health department to discuss your options for vaccination.

If you have any questions about the 2009 H1N1 influenza vaccine, call your child's healthcare provider or your local health department. Information is also available from the Maryland Department of Health and Mental Hygiene at www.dhmm.state.md.us/swineflu/ or at www.flu.gov.

All of the information that you have provided will be kept confidential. If you would like a copy of the Notice of Privacy Practices, it is available at www.hhs.gov/ocr/hipaa.

Section 3: Consent

CONSENT FOR CHILD'S VACCINATION:

By signing this form, I give permission for my child to be vaccinated and I agree that:

- The information above is correct.
- I have read the "2009 H1N1 Influenza Vaccine Information Statement" or someone has read it to me.
- I understand the risks and benefits of getting the H1N1 vaccine.
- Any questions I had about the vaccine have been answered.
- I have been offered a copy of the Notice of Privacy Practices.

Signature of Parent / Legal Guardian _____ Date: month _____ day _____ year _____

Section 4: Vaccination Record

FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Dose Administered	Dose Number (1st or 2nd)	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator Location of Vaccination Clinic	Provider Number
2009 H1N1 Injectable (IM)	/ /		<input type="checkbox"/> CSL <input type="checkbox"/> GSK <input type="checkbox"/> Novartis <input type="checkbox"/> Sanofi			