GROUP/PROVIDER ______ FOR NURSE USE ONLY: __LAIV-M ___H1N1-INJ. __NEEDS BOOSTER

ST. MARY'S COUNTY HEALTH DEPARTMENT SCHOOL/CHILD 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:

Question	
1. Did you child receive seasonal flu vaccine this year?	□ Yes □ No
2. Has your child ever had a serious allergic reaction to flu vaccine?	□ Yes □ 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.	□ Yes □ 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)]?	□ Yes □ No
5. Has a health care provider said that your child was wheezing or has asthma?	□ Yes □ No
6. Does your child have cancer, leukemia, AIDS, or any other immune system problem, including the removal of the spleen?	□ Yes □ No
7. Has your child taken cortisone, prednisone, other steroids, *nose sprays*, anticancer drugs, or nebulizer or x-ray treatments? When?	□ Yes □ No
8. Is your child taking medicine containing aspirin? Drug/dose____________________	□ Yes □ No
9. Has your child had Guillian-Barre syndrome?(a temporary ascending paralysis)	□ Yes □ No
10. Has your child received any vaccines in the past 4 weeks? Does your child have an appt. for any this month?	□ Yes □ 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)?	□ Yes □ No
12. Has your child had a blood transfusion or blood products, or immune (gamma) globulin? When?	□ Yes □ No
13. For females: Is the child pregnant or planning pregnancy in the next month?	□ Yes □ 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 #** *VIS 10/2/09* **Exp** *nasal* **H1N1 Injection/** *Sanofi Pasteur* **Lot #** **Exp** *VIS 10/2/09* **RA** *or* **LA** *IM*

H1N1 Influenza Vaccine #2 *Date Administered* *By*

H1N1 Nasal mist/*MedImmune* **Lot #** *VIS 10/2/09* **Exp** *nasal* **H1N1 Injection/** *Sanofi Pasteur* **Lot #** **Exp** *VIS 10/2/09* **RA** *or* **LA** *IM*