

## 2009 H1N1 Influenza Vaccine Consent Form for Children

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

CHILD'S NAME (Last)		(First)	(M.I.)	CHILD'S DATE OF BIRTH month _____ day _____ year _____	
PARENT/LEGAL GUARDIAN'S NAME (Last)		(First)	(M.I.)	CHILD'S AGE	CHILD'S GENDER M / F
ADDRESS			PARENT/GUARDIAN DAYTIME PHONE NUMBER:		
CITY	STATE	ZIP			

### 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
- My child has not been vaccinated with H1N1 influenza vaccine.

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

**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.**

	YES	NO
1. Does your child have a serious allergy to eggs or gelatin?	<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 (injection and nasal spray). Your answers to the following questions will help us know which of the two kinds of vaccine your child can get. A registered nurse will determine which kind of vaccine will be given based on answers and vaccine availability.**

	YES	NO
1. Has your child gotten vaccinated with any vaccine (including flu) within the past 30 days? Vaccine: _____ Please circle: <i>Shot / Nasal Spray</i> Date given: month _____ day _____ year _____	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your child have any of the following: asthma, wheezing, use an inhaler, seizures, cerebral palsy, 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)?	<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"/>
7. Is your child allergic to gentamicin or amino acid arginine?	<input type="checkbox"/>	<input type="checkbox"/>
8. Has your child taken antiviral medications in the last 48 hours?	<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 and benefits. I understand that if my child is 9 years old or younger he/she will need a 2<sup>nd</sup> dose in 4 weeks. I understand that this information may be shared with other health care providers directly involved in my child's care. I understand that this information will be entered into a statewide online vaccine registry.

I GIVE CONSENT to the Wood 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: month \_\_\_\_\_ day \_\_\_\_\_ year \_\_\_\_\_

### Section 4: Vaccination Record

#### FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Dose Administered	Route/Site	Dose Number (1st or 2nd)	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator
2009 H1N1		<input type="checkbox"/> IM _____ <input type="checkbox"/> Intranasal				
2009 H1N1		<input type="checkbox"/> IM _____ <input type="checkbox"/> Intranasal				

