

**Student Consent Form and
H1N1 Influenza Vaccine Immunization Nursing Record**

PLEASE PRINT

Student's Last Name: _____ Student's First Name: _____ Middle Initial: ____
 Address: _____ City: _____ Zip Code: _____
 Home Phone: _____ Emergency Contact Number: _____ Gender: (M / F)
 Child's Pediatrician / Physician: _____ DOB: _____ Age: _____
 Mother's Last Name: _____ Mother's First Name: _____
 Father's Last Name: _____ Father's First Name: _____
 OR, Guardian, if under 18: Last Name: _____ First Name: _____ Relationship: _____

If you answer **YES** to one or more of the following three questions, your child **will not** be able to receive the H1N1 vaccination at school.

The following questions will help us to determine if your child can receive the H1N1 Influenza Vaccine. Please CHECK YES or NO to <u>ALL</u> questions below for the STUDENT.	YES	NO
1. Does your child have an allergy to eggs, latex, MSG, or gentamycin?	<input type="checkbox"/>	<input type="checkbox"/>
2. Has your child ever had Guillain-Barré syndrome?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has your child ever had a reaction to a previous flu vaccine? If yes, please describe:	<input type="checkbox"/>	<input type="checkbox"/>
Please list any allergies:		

The following questions will help us to determine if your child can receive the Flu Mist. Please CHECK YES or NO to <u>ALL</u> questions below for the STUDENT.	YES	NO
1. Has your child received a vaccine within the past 30 days? Name of Vaccine(s): _____ Date Given: _____	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your child have <u>any</u> of the following: asthma, diabetes or metabolic diseases/disorders, or disease of the lungs, heart, kidneys, liver, nerves or blood?	<input type="checkbox"/>	<input type="checkbox"/>
3. Is your child pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
4. Is your child on long-term aspirin therapy (e.g. does your child take aspirin everyday)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Does your child have a disease such as cancer, lupus, HIV/AIDS, or do they take medication that lowers the body's resistance to infection?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does your child have close contact with anyone who has had a bone marrow transplant in the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>

Request for Administration of H1N1 Influenza Vaccine for the above named recipient: I understand that my child will not receive the vaccine if he/she is uncooperative. I have read information about the vaccine, special precautions on the Vaccine Information Sheet, and reviewed the Notice of Privacy Practices form. I have had an opportunity to ask questions regarding the vaccine and understand the risks and benefits. I request and voluntarily consent that the vaccine be given to the person above of whom I am parent or legal guardian and acknowledge no guarantees have been made concerning the vaccine's success.

If you **WANT** an H1N1 Influenza Vaccination given to your child check **YES – ADMINISTER** and **SIGN**.

YES – ADMINISTER _____ ADMINISTER FLU MIST IF AVAILABLE AND ELIGIBLE
 Parent / Guardian Signature _____ Date _____

FOR ADMINISTRATIVE USE ONLY

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

Bring this form with you to the vaccine clinic