

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

PLEASE PRINT *Everyone **Must** Complete this Section*

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. Please consult your family physician. You must **also** check **DO NOT ADMINISTER** and **SIGN** the next section.

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:		

If you DO NOT want an H1N1 Influenza Vaccination given to your child check DO NOT ADMINISTER and SIGN.

**DO NOT
ADMINISTER**

Parent / Guardian Signature

Date

The following questions will help us to determine if your child can receive the Flu Mist (live virus). 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.

This Consent Form may be used to administer a second dose of H1N1 Influenza Vaccine, if needed. I understand that I should report any changes of the above information prior to vaccination.

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

**YES –
ADMINISTER**

Parent / Guardian Signature

Date

**ADMINISTER FLU MIST
IF AVAILABLE AND
ELIGIBLE**

REMOVE this page from packet and return to school

VACCINATION RECORD**FOR ADMINISTRATIVE USE ONLY**

Vaccine	Date Dose Administered	Route	Dose Number (1st or 2nd)	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			
2009 H1N1	/ /	<input type="checkbox"/> IM <input type="checkbox"/> Intranasal		<input type="checkbox"/> Left <input type="checkbox"/> Right			