

Consent Form for 2009 H1N1 Influenza Vaccine



Child's Name _____
 (Last) (First) (MI)
Date of Birth _____ **Age** _____ **Gender** ___ Male ___ Female
Parent/Legal Guardian's Name _____ **Daytime PH #** _____
Address _____
 (Street) (City) (Zip)

The following questions will help us to know if your child can receive the 2009 H1N1 Influenza vaccine. Please mark YES or NO for each question.

If you answer "NO" to ALL of the following questions, your child can probably receive the 2009 H1N1 Influenza vaccine. If you answer "YES" to one or more of the following questions, your child may be able to get the 2009 H1N1 Influenza vaccine, but we will contact you to discuss your options.	YES	NO
Is your child allergic to latex, eggs, or thimerosal?		
Has your child ever been paralyzed with Guillain-Barre Syndrome?		
Does your child have an active neurological disorder, such as seizures?		

There are two kinds of 2009 H1N1 Influenza vaccine. Your answers to the following questions will help us know which of the two kinds of vaccine your child can receive.	YES	NO
Has your child been vaccinated with any vaccine (not just flu) within the past 30 days? Vaccine: _____ Date given: month _____ day _____ year _____		
Does your child have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood?		
Is your child on long-term aspirin or aspirin-containing therapy (for example, does your child take aspirin every day)?		
Does your child have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)?		
Is your child pregnant or planning to become pregnant in the next month?		
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)?		

Consent for Child's Vaccination: I have read or had explained to me the 2009-2010 Vaccine Information Statement (VIS) for the 2009 H1N1 Influenza vaccine and understand the risks and benefits; and I understand that the data from this form will be shared with other medical care providers to avoid unnecessary vaccination and to ascertain immunization status. **(VIS Dated 10/02/09)**

<p>I GIVE CONSENT to the Knox County Health Department and its staff for my child named at the top of this form to be vaccinated with this vaccine. (If this consent form is not signed, dated, and returned, then your child will not be vaccinated at school)</p> <p>Signature of Parent/Legal Guardian</p> <p>_____</p> <p>Date: month _____ day _____ year _____</p>	<p>I DO NOT GIVE CONSENT to the Knox County Health Department and its staff for my child named at the top of this form to be vaccinated with this vaccine.</p> <p>Signature of Parent/Legal Guardian</p> <p>_____</p> <p>Date: month _____ day _____ year _____</p>
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FOR CLINIC USE (this section must be completed by the medical provider)

Clinic Location _____ IMPACT SIIS entry completed <input type="checkbox"/>	1st Dose: Date Vaccinated _____ Provider Signature _____ Vaccine used (check one): <input type="checkbox"/> Intranasal H1N1 2009 <input type="checkbox"/> Injection H1N1 2009 Lot # _____ Site of Injection _____	2nd Dose (if needed): Date Vaccinated _____ Provider Signature _____ Vaccine used (check one): <input type="checkbox"/> Intranasal H1N1 2009 <input type="checkbox"/> Injection H1N1 2009 Lot # _____ Site of Injection _____
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