

**IM or Intranasal**

**Miami-Dade County Health Department  
2009 H1N1 Influenza Vaccine Consent Form**

For your child to be eligible to receive the H1N1 Influenza vaccine at the school, **you must answer all questions and sign this consent form.** Depending on your answers and the availability of the vaccine, your child will receive either the injectable or the intranasal flu vaccine. Please read both vaccine information statements we have provided for you. If this is the 1<sup>st</sup> time that a child under 10 years of age receives the H1N1 influenza vaccine, then s/he will receive a 2nd dose of the flu vaccine at the school site 4 weeks after the 1<sup>st</sup> dose. This consent form will cover both flu vaccine doses, if needed.

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

STUDENT'S NAME (Last)		(First)	(M.I.)	STUDENT'S DATE OF BIRTH Month _____ Day _____ Year _____	
PARENT/LEGAL GUARDIAN'S NAME (Last)		(First)	(M.I.)	STUDENT'S AGE	STUDENT'S GENDER Male or Female
RELATIONSHIP TO CHILD		LIST CHILD'S RACE		SOCIAL SECURITY (OPTIONAL)	
ADDRESS			PARENT/GUARDIAN DAYTIME PHONE NUMBER:		
CITY / COUNTY	STATE	ZIP			
SCHOOL NAME			GRADE		

**Section 2: Screening for Vaccine Eligibility**

If your child has already been vaccinated with 2009 H1N1 influenza vaccine, please tell us the 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

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

**A. If you answer "NO" to all 4 of the following questions, your child can probably get the H1N1 influenza vaccine. If you answer "YES" to 1 or more of the following questions, your child will be screened to determine his/her eligibility.**

Please check Yes or No for each question.	YES	NO
1. Does your child have an allergy to eggs?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your child have any other allergies? Please list _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Has your child ever had a reaction to a previous dose of flu vaccine or to any other type of 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 2 kinds of 2009 H1N1 influenza vaccine. Your answers will help us know which vaccine your child can get.**

Please check Yes or No for each question.	YES	NO
1. Has your child gotten vaccinated with any vaccine (not just flu) within the past 30 days? Vaccine: _____ Date given: Month _____ Day _____ Year _____	<input type="checkbox"/>	<input type="checkbox"/>
2. 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?	<input type="checkbox"/>	<input type="checkbox"/>
3. Is your child on long-term aspirin or aspirin-containing therapy (i.e., does your child take aspirin every day)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Does your child have a weak immune system (i.e., HIV, cancer, or takes 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 has a severely weakened immune system (i.e., requiring care in a protected environment, such as a bone marrow transplant)?	<input type="checkbox"/>	<input type="checkbox"/>

**Section 3: Consent**

**CONSENT FOR MY CHILD'S VACCINATION:**

I have read the 2009-2010 Vaccine Information Statement for the 2009 H1N1 influenza vaccine and understand the risks and benefits.

I GIVE CONSENT for my child to be vaccinated by the school nurse with the 2009 H1N1 influenza vaccine.

(If this consent form is not signed, dated, and returned, then your child will not be vaccinated at the school).

Signature of Self or Parent/Legal Guardian \_\_\_\_\_ Date: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**FOR ADMINISTRATIVE USE ONLY**

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