

2009 H1N1 FLU VACCINE CONSENT
 School Clinic (Injectable and /or Nasal spray)

Information collected on this form will be used to document permission for your child to receive the 2009 H1N1 influenza vaccine at your child's school. Record of this immunization may be shared through the Wisconsin Immunization Registry (WIR) with other health care providers directly involved with your child's care.

SCHOOL: _____ City: _____

Student's Name (Last, First, Middle initial)			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		
Student's Birthdate Month _____ Day _____ Year _____		Student's Age	School Grade	Parent/Guardian Daytime Phone Number () _____	
Home Address		P. O. Box	City	County	State Zip Code
Parent/Guardian's Name					
Okay to share H1N1 immunization data with the Wisconsin Immunization Registry (WIR)? <input type="checkbox"/> Yes <input type="checkbox"/> No					

Please answer the following questions (circle Yes or No):

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|---|------------|-----------|
| 1. Does your child have a serious allergy to eggs? | Yes | No |
| 2. Does your child have any other serious allergies? Please list _____ | Yes | No |
| 3. Has your child ever had a serious reaction or allergic response to past flu vaccinations? | Yes | No |
| 4. Has your child ever had Guillian Barré syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine? | Yes | No |

There are two types of 2009 H1N1 influenza vaccine (Shot or Nasal Spray). Your answers to the following questions will help us know which of the two kinds of vaccine your child can receive.

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|---|------------|-----------|
| 5. Has your child been vaccinated with any vaccine (including H1N1) within the past 4 weeks? (for example, nasal spray influenza, MMR, Varicella, etc)? List Vaccine(s): _____ Date received: _____ | Yes | No |
| 6. 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? | Yes | No |
| 7. Is your child on long-term aspirin or aspirin-containing therapy (for example, does your child take aspirin every day)? | Yes | No |
| 8. Does your child have a weakened immune system (for example, from HIV, cancer, or medications such as steroids)? | Yes | No |
| 9. Is your child pregnant? | Yes | No |
| 10. Does your child have close contact with a person whose immune system is severely compromised and who must be in a protective isolation (such as in a hospital room with reverse air flow)? | Yes | No |

CONSENT FOR CHILD'S VACCINATION:

I have read, or have had explained to me, the 2009 Vaccine Information Statement for 2009 H1N1 influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine be given to the student named above for whom I am authorized to make this request.

Signature X _____ Date _____

FOR OFFICE USE	VIS date: 10/02/009
2009 H1N1: Route (circle one) = IM or Intranasal (IN) Body site (circle one) = RD or LD or IN Dose (circle one): 1 or 2	
Manufacturer _____	Lot No. _____
Signature and title of person administering vaccine: _____	
Date vaccine administered: _____	