Minnesota 2009 H1N1 Influenza Vaccine School Consent Form

(Injection or Nasal Spray)

Information about Child to Receive Vaccine (Please Print)

STUDENT'S NAME (Last)	(First)	(M.I.)	**STUDENT'S DATE OF BIRTH** Month_____ Day_____ Year _____	
MOTHERS MAIDEN NAME (LAST)			**STUDENT'S AGE**	**STUDENT'S GENDER** M / F
ADDRESS				
CITY	**STATE**	**ZIP**	**PARENT/GUARDIAN DAYTIME PHONE NUMBER:**	
SCHOOL NAME		**GRADE**	**HOMEROOM TEACHER**	

Screening for Vaccine Eligibility

The answers to the following questions will help us determine if your child can get the 2009 H1N1 influenza vaccine. Please mark YES or NO for each question.	**YES**	**NO**
1. Does your child have a serious allergy to eggs?	☐	☐
2. Does your child have any other serious allergies? Please list: _____	☐	☐
3. Has your child ever had a serious reaction to a previous dose of influenza vaccine?	☐	☐
4. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness)?	☐	☐

Your answers to the following questions will help us know which type of vaccine your child can get (Injection or Nasal Spray).	**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_____	☐	☐
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?	☐	☐
3. Is your child on long-term aspirin or aspirin-containing therapy? (For example, does your child take aspirin every day)	☐	☐
4. Does your child have a weak immune system? (For example, from HIV, cancer, or medications such as steroids or those used to treat cancer)?	☐	☐
5. Is your child pregnant?	☐	☐
6. Does your child visit a hospitalized person who needs care in a protected environment? (For example, a hospitalized person who has had a bone marrow transplant)	☐	☐
If your child is started on an Antiviral medication before the scheduled school vaccination clinic, please contact the school health services office.		

If you have answered no to all of the above questions, your child qualifies for either type of vaccine. Which would you prefer?

____Injection (Shot) ____Nasal Spray

If no preference is indicated, your child will receive vaccine based on availability.

CONSENT FOR CHILD'S VACCINATION:

I GIVE CONSENT to the STATE/LOCAL health department and its staff for my child named at the top of this form to be vaccinated with this vaccine. I have received the 2009-2010 Vaccine Information Statement for the 2009 H1N1 influenza vaccine and understand the risks and benefits.

I understand that the information contained within this record is being maintained to monitor immunization needs in order to prevent disease. This information is confidential and will only be shared with organizations or persons who are authorized by law to receive it. This includes the Minnesota Department of Health, a health care provider or health care organization providing services on behalf of the child, the child's school or childcare and anyone else authorized under law to receive it. This information will be included in the Minnesota Immunization Information Connection Registry, a secure web-based registry system for health care providers. If you choose not to have your child's information shared with registry please call 1-800-657-3970.

Signature of Parent/Legal Guardian _____ **Date:** _____

(Your child will not be vaccinated if this consent form is not signed, dated, and returned.)

RETURN THIS FORM TO THE HEALTH SERVICES OFFICE AT YOUR CHILD'S SCHOOL

FOR ADMINISTRATIVE USE ONLY

Vaccine	**Date Dose Administered**	**Route**	**Dose**	**Injection Site**	**Vaccine Manufacturer**	**Lot Number**
2009 H1N1	/ /	☐ IM ☐ Intranasal	☐ 0.25 ml ☐ 0.5 ml ☐ 0.2 ml			
Name and Title of Vaccine Administrator						