

Polk County Health Department
2009 H1N1 Influenza Vaccine School Consent Form
Intramuscular or Intranasal

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 M / F
ADDRESS					PARENT/GUARDIAN DAYTIME PHONE NUMBER:	
CITY	STATE	ZIP				
SCHOOL NAME					GRADE	

Please answer the following questions by circling "YES" or "NO".

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 to a previous dose of flu vaccine?	YES	NO
4. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	YES	NO

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 get. (Please circle "YES" or "NO")

1. Has your child been vaccinated with any vaccine (not just flu) within the past 30 days? If yes, please indicate type and date. Vaccine: _____ Date given: month _____ day _____ year _____	YES	NO
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?	YES	NO
3. Is your child on long-term aspirin or aspirin-containing therapy (for example, does your child take aspirin every day)?	YES	NO
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)?	YES	NO
5. Is your child pregnant?	YES	NO
6. 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)?	YES	NO
7. Do you prefer your child get one type of vaccine over another? If "YES" check which kind of vaccine below that you want your child to have. Your child may not receive this preferred vaccine if he/she has a medical contraindication or if that vaccine is unavailable. _____ Flu Mist (intranasal) _____ Inject able (Intramuscular)	YES	NO

Please circle "YES" or "NO" for each consent item and sign below. Your child will not receive the H1N1 vaccination without a parent or guardian signature.

1. I have read or had explained to me the 2009-2010 Vaccine Information Statement for the 2009 H1N1 influenza vaccine and understand the risks and benefits. This consent allows for the Polk County Health Department to administer H1N1 vaccine to the child listed above.	YES	NO
2. I consent to sharing H1N1 Immunization Data with the Wisconsin Immunization Registry (WIR):	YES	NO
3. If your child is covered by health insurance, I consent to allow the Polk County Health Department to bill my private insurance company for an administration fee.	YES	NO
Insurance Company Name: _____ Mailing Address: _____ _____ City: _____ State: _____ Zip: _____ Group #: _____ ID #: _____ Subscriber Name: _____		

Parent or Guardian Signature: _____ Date: _____

FOR ADMINISTRATIVE USE ONLY

Dose	Date Dose Administered	Route	IM Site	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator
1		IM Intranasal	LD RD			
2		IM Intranasal	LD RD			