

**Hendricks County Health Department
2009 H1N1 Influenza Vaccine Consent Form**

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 M / F
ADDRESS			PARENT/GUARDIAN DAYTIME PHONE NUMBER:		
CITY	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 number of 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 for each question.

A. If you answer "NO" to all four of the following questions, your child is eligible to receive the influenza vaccine. If you answer "YES" to one or more of the following four questions, your child will be ineligible to receive the influenza vaccine at this clinic. Please contact your healthcare provider.

	YES	NO
1. Does your child have a serious allergy to eggs?		
2. Does your child have any other serious allergies?		
3. Has your child ever had a serious reaction to a previous dose of flu vaccine?		
4. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?		

Section 3: Consent

CONSENT FOR CHILD'S VACCINATION:

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. I consent to my child being vaccinated even without my presence.

I GIVE CONSENT to the Hendricks County Health Dept or its designee for my child named at the top of this form to be vaccinated with up to two doses of H1N1 vaccine spaced at least 21 days apart.
 (If this consent form is not signed, dated, and returned, then your child will not be vaccinated at school)

Signature of Parent/Legal Guardian _____
 Date: month ____ day ____ year ____

I DO NOT GIVE CONSENT to the Hendricks County Health Dept or its designee for my child named at the top of this form to be vaccinated with this vaccine.

Signature of Parent/Legal Guardian _____
 Date: month ____ day ____ year ____

Section 4: Permission to Release Information

All vaccines administered will be entered into the Children and Hoosier Immunization Registry Program (CHIRP) by the Hendricks County Health Department.

Section 5: Vaccination Record

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	/ /	IM				
2009 H1N1	/ /	IM				