

## Zanesville-Muskingum County Health Department CHILD- 2009 H1N1 Influenza Vaccine Consent Form

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

CHILD'S NAME (Last)		(First)	(M.I.)	CHILD'S DATE OF BIRTH month _____ day _____ year _____	
PARENT/LEGAL GUARDIAN'S NAME (Last)		(First)	(M.I.)	CHILD'S AGE	GENDER M / F
ADDRESS			PARENT/GUARDIAN DAYTIME PHONE NUMBER:		
CITY	STATE	ZIP			

**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 can probably get the influenza vaccine. If you answer "YES" to one or more of the following four questions, your child may be able to get the 2009 H1N1 vaccine, but we will discuss your options.**

	YES	NO
1. Does your child have a serious allergy to eggs?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your child have any other serious allergies? Please list: _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Has your child ever had a serious reaction to a previous dose of flu 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 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.**

	YES	NO
1. Has your child been vaccinated with any flu vaccine 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 (for example, does your child take aspirin every day)?	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<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 needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?	<input type="checkbox"/>	<input type="checkbox"/>

**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 GIVE CONSENT 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 \_\_\_\_\_

I DO NOT GIVE CONSENT 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**

**CONSENT FOR OHIO IMMUNIZATION REGISTRY INFORMATION SYSTEM:**

I also give permission to enroll my child's immunization records into the Ohio Department of Health vaccine registry (SIIS) to ensure this vaccination record is available to me and my healthcare providers. I understand I may be asked for information that will ensure my records are accurate and will not be confused with another person's records. I authorize inclusion of all information into SIIS and redisclosure of this information from SIIS to authorized users such as the Center for Disease Control, CDC.

Signature \_\_\_\_\_ Date: month \_\_\_\_\_ day \_\_\_\_\_ year \_\_\_\_\_

**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	/ /	<input type="checkbox"/> IM <input type="checkbox"/> Intranasal				
2009 H1N1	/ /	<input type="checkbox"/> IM <input type="checkbox"/> Intranasal				