

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. If you answer "NO" to all of the following questions, your child can probably get the influenza vaccine. If you answer "YES" to one or more of the following seven questions, your child may not be able to get the 2009 H1N1 vaccine.

	YES	NO
1. Does your child have an allergy to eggs?		
2. Does your child have any other allergies that you know of? Please list: _____		
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)?		
5. Has your child gotten vaccinated with any vaccine (not just flu) within the past 30 days? Vaccine: _____ Date given: month ____ day ____ year _____		
6. Is your child on long-term aspirin or aspirin-containing therapy (for example, does your child take aspirin every day)?		
7. 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)?		

The intranasal vaccine for H1N1 will only be given to students without significant health conditions (for example, asthma, diabetes, sickle cell anemia, HIV, cancer, seizure disorders). If your child has any of these conditions, contact your child's physician to receive the H1N1 vaccine.

To the best of my knowledge, my child does not have any of the listed health conditions.

Signature of Parent/Legal Guardian _____

Section 3: Consent

CONSENT FOR CHILD'S VACCINATION:

I have read or had explained to me the attached 2009-2010 Vaccine Information Statement (VIS) for the 2009 H1N1 influenza vaccine and I understand the risks and benefits. I also understand that my child's information must be reported to Philadelphia Department of Public Health and the Centers for Disease Control and Prevention for receipt of the H1N1 influenza vaccine.

I HEREBY GIVE CONSENT to St. Joseph's Prep and the Philadelphia Department of Public Health for my child to get vaccinated with the H1N1 influenza vaccine. On behalf of myself and my child, I hereby release, discharge, waive and agree to hold harmless, St. Joseph's Prep and their officers, employees, and contractors, from and against any and all liabilities, losses, and claims, including without limitation, for personal injury or death, arising from or relating to, the vaccination of my child.

Signature of Parent/Legal Guardian _____

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	/ /	IM Intranasal				
2009 H1N1	/ /	IM Intranasal				