



2009 H1N1 (SWINE FLU) FluMist SECOND DOSE

School Vaccine Consent Form

Note: A second dose is recommended for all children 9 years and younger.

Student Last name:		Student First Name:		Student Date of Birth:	Age on vaccination day:
Student Address:			City:	State:	Zip Code:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Race (Check all that apply): <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> Other _____			Hispanic/Latino?: <input type="checkbox"/> Yes <input type="checkbox"/> No	
School:		Student's Teacher:		Student's Grade:	

Medical Screening:

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Does your child have a long-term health problem such as heart disease, kidney disease, lung disease, liver disease, diabetes, or a blood disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Has your child ever had any form of asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Has your child ever had a serious reaction, such as difficulty breathing, to eggs or a flu vaccine? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. On a regular basis or frequently, does your child take medicine that has aspirin in it? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Does your child have a very weak immune system caused by cancer, cancer treatment, HIV, an organ transplant, or any other drugs that weakens the immune system? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Has a doctor ever said your child has Guillain-Barré syndrome (a serious nervous system disorder)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Does your child live with anyone who has a severe immune system condition that requires care in a protected environment, like an organ transplant, cancer treatment or AIDS?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Has your child received a vaccine for measles, mumps, rubella, chickenpox, <u>or FluMist (H1N1 or seasonal)</u> in the last month? If yes, date vaccine received _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Is your child pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Did your child receive FluMist for the first dose of H1N1? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, date dose 1 received _____ | | |

Consent and Request to Receive H1N1 Vaccination (please check box if agreed)

- I have read the information recorded above and certify that it is correct.
- I have received a copy of the Centers for Disease Control and Prevention (CDC) 2009 H1N1 Influenza Vaccine Information Statement (VIS) dated 10/2/09 and have read or had explained to me the information in the VIS.
- I have had an opportunity to ask questions about the 2009 H1N1 Influenza vaccine and they were answered to my satisfaction.
- I have received or been offered a copy of the Notice of Privacy Practices.
- I understand the risks and benefits of receiving the 2009 H1N1 Influenza vaccination and hereby give my consent to having the 2009 H1N1 Influenza vaccination administered to me or to the person named above for whom I am authorized to consent.

Signature of Parent/Guardian

Printed/Guardian Parent Name

Date

For Clinic Use Only:

Clinic Date: _____ Date VIS given: _____
 Administration site: L Arm R Arm Intranasal (Mist)
 Pediatric dose: _____ L Thigh R Thigh

Affix Label Here (Manufacturer, Lot #,
Expiration Date, Vaccinator Initials)