

**2009 H1N1 INFLUENZA VACCINE  
SCHOOL CONSENT & ADMINISTRATION RECORD**

**PLEASE PRINT INFORMATION ABOUT PERSON TO RECEIVE VACCINE**

Student's Name (Last)			(First)		(M I)
Parent/Guardian Name			Daytime Phone		Mother's Maiden Name (Last)
Address		Apt #	City		Zip
County		Age		Sex	
Month	Day	Year	<input type="checkbox"/> Male		<input type="checkbox"/> Female
School Name			Grade	Teacher/Advisor	

- |  |                          |                          |
|--|--------------------------|--------------------------|
|  | <b>YES</b>               | <b>NO</b>                |
| 1. Does your child have a serious allergy to eggs?                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Has your child ever had a serious reaction to a previous dose of Influenza vaccine? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Has your child ever had Guillain-Barre Syndrome? (temporary severe muscle weakness) | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Does your child have any other serious allergies?                                   | <input type="checkbox"/> | <input type="checkbox"/> |
- Please list \_\_\_\_\_

**Your answers to the following questions will help us know which type of vaccine your child can get  
(Injection or Nasal Spray)**

- |   |                          |                          |
|---|--------------------------|--------------------------|
|   | <b>YES</b>               | <b>NO</b>                |
| 5. Has your child received any vaccinations within the past 30 days?<br>What? _____ Date? _____ If seasonal flu, what type? <input type="checkbox"/> Shot <input type="checkbox"/> Mist | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. 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"/> |
| 7. Is your child on long-term aspirin or aspirin-containing therapy?<br>(For example, does your child take aspirin every day)   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Does your child have a weak immune system?<br>(For example, from HIV, cancer or medications such as steroids or those used to treat cancer)  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Is your child pregnant?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Does your child visit a hospitalized person who needs care in a protected environment?<br>(For example, a hospitalized person who has had a bone marrow transplant)                 | <input type="checkbox"/> | <input type="checkbox"/> |

*If your child is started on an Antiviral medication before the scheduled school vaccination clinic, contact the **SCHOOL NURSE***

**CONSENT FOR CHILD'S VACCINATION**

I GIVE CONSENT to the STATE/LOCAL health department and its staff for my child named at the top of this form to be vaccinated with this vaccine. I have received the 2009-2010 Vaccine Information Statement for the 2009 H1N1 influenza vaccine and understand the risks and benefits. I understand that the information contained within this record is being maintained to monitor immunization needs in order to prevent disease. This information is confidential and will only be shared with organizations or persons who are authorized by law to receive it. This includes the Minnesota Department of Health, a health care provider or health care organization providing services on behalf of the child, the child's school or childcare and anyone else authorized under law to receive it. This information will be included in the Minnesota Immunization Information Connection Registry, a secure web-based registry system for health care providers. If you choose not to have your child's information shared with registry please call 1-800-657-3970.

Signature of Parent/Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

**YOUR CHILD WILL NOT BE VACCINATED IF THIS CONSENT FORM IS NOT SIGNED, DATED, AND RETURNED**

**DOSE 1**

Vaccine Mfr and Lot \_\_\_\_\_

Date Vaccine Administered \_\_\_\_\_ 2009

Route  IM 0.5 ml  Intranasal 0.2 ml

Deltoid  Left  Right

Name of Vaccine Administrator \_\_\_\_\_

DATE OF VIS 10/02/2009

Accounting Staff Only Stats Done \_\_\_\_\_ MIIC Done \_\_\_\_\_

**DOSE 2**

Vaccine Mfr and Lot \_\_\_\_\_

Date Vaccine Administered \_\_\_\_\_ 2009

Route  IM 0.5 ml  Intranasal 0.2 ml

Deltoid  Left  Right

Name of Vaccine Administrator \_\_\_\_\_

DATE OF VIS 10/02/2009

Accounting Staff Only Stats Done \_\_\_\_\_ MIIC Done \_\_\_\_\_