

**THIS FORM MUST BE SIGNED AND RETURNED BEFORE YOUR CHILD RECEIVES VACCINE****Minnesota 2009 H1N1 Influenza Vaccine School Consent Form**

(Injection or Nasal Spray)

**Information about Child to Receive Vaccine (Please Print)**

STUDENT'S NAME (Last)		(First)	(M.I.)	STUDENT'S DATE OF BIRTH Month _____ Day _____ Year _____	
MOTHERS MAIDEN NAME (LAST)			STUDENT'S AGE	STUDENT'S GENDER M / F	
ADDRESS					
CITY		STATE	ZIP	PARENT/GUARDIAN DAYTIME PHONE NUMBER:	
SCHOOL NAME			GRADE		

**Screening for Vaccine Eligibility**

<b>The answers to the following questions will help us determine if your child can get the 2009 H1N1 influenza vaccine. Please mark YES or NO for each question.</b>	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 influenza vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness)?	<input type="checkbox"/>	<input type="checkbox"/>

<b>Your answers to the following questions will help us know which type of vaccine your child can get (Injection or Nasal Spray).</b>	YES	NO
1. Has your child gotten vaccinated with any vaccine (not just flu) 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 visit a hospitalized person who needs care in a protected environment? (For example, a hospitalized person who has had a bone marrow transplant)	<input type="checkbox"/>	<input type="checkbox"/>
<b>If your child is started on an Antiviral medication before the scheduled school vaccination clinic please notify your school nurse.</b>		

**Your signature on this form will be a record of your consent for up to two doses of the H1N1 Influenza Vaccine for your child.  
Your child will receive vaccine based on availability.**

<b>CONSENT FOR CHILD'S VACCINATION:</b>
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 <b>not</b> be vaccinated if this consent form is not signed, dated, and returned.)

**FOR ADMINISTRATIVE USE ONLY**

Vaccine	Date Dose Administered	Route	Dose	Injection Site	Vaccine Manufacturer	Lot Number
2009 H1N1	/ /	<input type="checkbox"/> IM <input type="checkbox"/> Intranasal	<input type="checkbox"/> 0.25 ml <input type="checkbox"/> 0.5 ml <input type="checkbox"/> 0.2 ml			
2009 H1N1	/ /	<input type="checkbox"/> IM <input type="checkbox"/> Intranasal	<input type="checkbox"/> 0.25 ml <input type="checkbox"/> 0.5 ml <input type="checkbox"/> 0.2 ml			
Name and Title of Vaccine Administrator				1.	2.	