

**Broward County Health Department  
2009 H1N1 Influenza Vaccine Consent Form**

For your child to be able to receive the H1N1 Influenza vaccine at the school, **you must answer all questions and sign this consent form**. Depending on your answers and the supply of the vaccine, your child will receive either a flu shot or a nasal flu spray. Please read both vaccine information statements we have provided for you. Children under age 10 receiving the H1N1 Influenza Vaccine for the first time will receive a 2nd dose of the flu vaccine at the school site about 4 weeks after the 1<sup>st</sup> dose. This consent form will cover both flu vaccine doses, if needed.

I WANT MY CHILD TO BE VACCINATED (PLEASE CHECK): \_\_\_ YES \_\_\_ NO (If NO, complete Section 1 **ONLY** and return this form to your school.)

**SECTION 1: INFORMATION ABOUT CHILD (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 SEX: M <input type="checkbox"/> F <input type="checkbox"/>	RACE:
ADDRESS				PARENT/GUARDIAN DAYTIME PHONE NUMBER (S):		
CITY	STATE	ZIP				
SCHOOL NAME				GRADE		

**SECTION 2: SCREENING FOR VACCINE ELIGIBILITY**

Answers to the following questions will help us decide if your child should receive the 2009 H1N1 influenza vaccine. Please mark YES or NO.

**A. If you answer "NO" to all 3 of the following questions, your child can probably get the H1N1 influenza vaccine. If you answer "YES" to 1 or more of the following questions, your child will be screened to determine his/her eligibility.**

<b>Please check Yes or No for each question.</b>	<b>YES</b>	<b>NO</b>
1. Does your child have an allergy to eggs?	<input type="checkbox"/>	<input type="checkbox"/>
2. Has your child ever had a reaction to a previous dose of flu vaccine or to any other type of vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
3. 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 2 kinds of 2009 H1N1 influenza vaccine. Your answers will help us decide which vaccine your child should get.**

<b>Please check Yes or No for each question.</b>	<b>YES</b>	<b>NO</b>
1. Has your child been vaccinated within the past 30 days? Vaccine: _____	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your child have any of the following: asthma, diabetes, disease of the lungs, heart, kidneys, liver, nerves, or blood?	<input type="checkbox"/>	<input type="checkbox"/>
3. For children 2 to 4 years of age, has your child been diagnosed with wheezing or asthma in the past year?	<input type="checkbox"/>	<input type="checkbox"/>
4. Does your child take aspirin on a regular basis?	<input type="checkbox"/>	<input type="checkbox"/>
5. Does your child have a weak immune system (eg.HIV, cancer, or takes medications such as steroids)?	<input type="checkbox"/>	<input type="checkbox"/>
6. Is your child pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
7. Does your child have close contact with a person who has a very weak immune system (such as a bone marrow transplant, chemotherapy etc...)?	<input type="checkbox"/>	<input type="checkbox"/>

**SECTION 3: CONSENT FOR CHILD'S VACCINATION**

**I have received, read and understand the Novel H1N1 Vaccine Information Statements (VIS). I have had the chance to ask questions and discuss my concerns with a healthcare professional. I give permission to the Broward County Health Department to give my child the Novel H1N1 vaccine in my absence.**

I \_\_\_\_\_ (PLEASE PRINT NAME of consenting adult ) have the following relation with the child named above (please check relationship to child):

Mother       Father       Legal Guardian       Grandmother       Grandfather       Adult Aunt  
 Adult Uncle       Adult Sister       Adult Brother       Stepfather       Stepmother       Court Order

**I have the legal authority, based on the relationship to the child as indicated above, pursuant to s.743.0645, F.S., to consent to this vaccine administration for the child named above.**

Signature: \_\_\_\_\_ Date: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**FOR ADMINISTRATIVE USE ONLY**

Vaccine	Date Dose Administered	Route	Dose Number (# 1 or 2)	Site (RDLT/LDLT; RAT/LAT)	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					