Grand Traverse County Health Department
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.

A. If you answer "NO" to all four of the following questions, your child can probably get the influenza vaccine. If you answer "YES" to one or more of the following four questions, your child <u>may</u> be able to get the 2009 H1N1 vaccine, but we will contact you to discuss your options.

	YES	**NO**
1. Does your child have a serious allergy to eggs?	☐	☐
2. Does your child have any other serious allergies? 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) within 6 weeks of receiving flu vaccine?	☐	☐

B. There are two types of 2009 H1N1 influenza vaccine (the nasal spray and the injectable) Your answers to the following questions will help us know which type your child can get.

	YES	**NO**
1. Has your child been given any vaccines, including any flu vaccine within the past 30 days? Vaccine: __________________________________ Date given: month______day________year_____________	☐	☐
2. Does your child have any of the following: recurrent wheezing, asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood?	☐	☐
3. Is your child on long-term aspirin or aspirin-containing therapy (for example, does your child take aspirin every day)?	☐	☐
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)?	☐	☐
5. Is your child pregnant?	☐	☐
6. 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)?	☐	☐
7. Has your child taken any influenza antiviral medications in the last week (ex.Tamiflu, Relenza)? When?	☐	☐

Section 3: Consent

CONSENT FOR CHILD'S VACCINATION:
I have read or had explained to me the Vaccine Information Statement for the 2009 H1N1 influenza vaccine and understand the risks and benefits. I understand that the Grand Traverse County Health Department Notice of Privacy Practices is available to review online at www.gtchd.org or I may request a copy by calling 231-922-4831.

I GIVE CONSENT to Grand Traverse County Health Department and its staff for my child named at the top of this form to be vaccinated with this vaccine.
(If this consent form is not signed, dated, and returned, then your child will not be vaccinated at school)

Signature of Parent/Legal Guardian ______________________

Date: month______day______year__________

I DO **NOT** GIVE CONSENT to Grand Traverse County Health Department and its staff for my child named at the top of this form to be vaccinated with this vaccine.

Signature of Parent/LegalGuardian______________________

Date: month______day______year__________

Voluntary Insurance Information

By providing medical insurance information below, I am authorizing Grand Traverse County Health Department to bill my insurance for the vaccine administration fee only. There will be NO out of pocket expense to me regardless of insurance coverage or results of billing my insurance.

Does your child have Medicaid? ☐ yes Number______________________________ ☐ no

Does your child have other health insurance? ☐ yes Type______________________________ ☐ no

Group Number________________________ Contract Number__________________________

Staff Only

Section 5: Vaccination Record

Clinic Site__________________________ **Date of VIS**__________________

FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Dose Administered	Route	Dose # (1st or 2nd)	Vaccine Manufacturer	Lot Number	Date VIS Given	Name and Title of Vaccine Administrator
2009 H1N1	/ /	☐ IM ☐ Intranasal				/ /	

Parent/guardian present ☐ yes ☐ no