

2010 H1N1 Flu Vaccine Consent Form --Injectable Flu Shot or Nasal Spray Vaccines (For use when parent is NOT present with child)

Winthrop Health Department, 1 Metcalf Square, Rm. 5, Winthrop, MA 02152

Section 1: Information about Child to Receive Vaccine (please print)

STUDENT'S NAME (Last)		(First)	(M.I.)	STUDENT'S DATE OF BIRTH / /	
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		
INSURANCE NAME:			INSURANCE #:		

Section 2: Screening for Vaccine Eligibility

If your child has already been vaccinated with 2010 H1N1 flu 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 2010 H1N1 flu vaccine. Please mark YES or NO for each question.

A. If you answer "YES" to one or more of the four questions, your child will not be able to receive the 2010 H1N1 flu vaccine in school unless there is a note from your child's health care provider approving the vaccination. If you answer "NO" to the following questions your child will receive the vaccine unless a concern arises following additional screening. If you are not sure of the answers to these questions, please check with your child's healthcare provider.

	YES	NO
1. Does your child have a serious allergy to eggs?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your child have a serious allergy to gentamicin, neomycin, polymixin or gelatin?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has your child ever had a serious reaction to a previous dose of flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
4. 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 two kinds of 2010 H1N1 flu vaccine. Your answers to the following questions will help us determine if your child is able to receive the nasal spray vaccine.

	YES	NO
1. Has your child been 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. If your child is 2-4 years of age, has a healthcare provider told you that your child had wheezing or asthma within the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
4. 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"/>
5. 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"/>
6. Is your child pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
7. 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)?	<input type="checkbox"/>	<input type="checkbox"/>

List other serious allergies: _____

Section 3: Consent

CONSENT FOR CHILD'S VACCINATION:

I have read or had explained to me the 2010 Vaccine Information Statement for the H1N1 influenza vaccine and understand the risks and benefits.

I GIVE CONSENT for my child named at the top of this form to get vaccinated with this vaccine. Children younger than 10 years of age need 2 doses of vaccine. (If this consent is not signed, dated and returned, then my child will not be vaccinated.)

Signature of Parent/Legal Guardian _____

Date: month ____ day ____ year ____

I DO NOT GIVE CONSENT for my child named at the top of this form to get vaccinated with this vaccine.

Signature of Parent/Legal Guardian _____

Date: month ____ day ____ year ____

PLEASE BE SURE TO READ AND SIGN THE REVERSE SIDE OF THIS FORM

Section 4: Permission to Share Information:

I, _____, give permission to the individual and/or entity that administered the 2010 H1N1 vaccine to my child _____ to share copies of the 2010 H1N1 consent form and vaccination record with my child's school and health care provider named below, as well as with the Massachusetts Department of Public Health and the local board of health in my community. I also give permission for each of these entities to share the 2010 H1N1 consent form and vaccination record with each other.

My child's health care provider: _____ My child's school: _____
 Name: _____ Name: _____
 Address: _____ Address: _____
 (at a minimum include Town)

- This health information is disclosed at my request and to ensure my child is appropriately vaccinated.
- This permission expires at the end of the 2009-2010 school year.
- If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information received may no longer be protected by federal privacy regulations. State privacy regulations cover information received by the MA Department of Public Health and local boards of health.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my child's ability to obtain the vaccination.
- I understand that I may inspect or copy the protected health information to be disclosed under this permission to share.
- Finally, I understand that I may withdraw this permission in writing at any time by sending written notification to:

Ro Sarro, RN/BSN PUBLIC HEALTH NURSE Phone #: 617-846-1740 ext 130
WINTHROP HEALTH DEPARTMENT, 1 METCALF SQUARE RM 5, WINTHROP, MA 02152

However, if I withdraw permission at a later date, any vaccine consent form and vaccine record already shared will not be covered by the withdrawal.

Printed name of Parent or Guardian _____ Signature of Parent or Guardian _____
 Address _____ Date _____

 For Clinic/Office Use: Contact Person: RO SARRO, RN/BSN, PUBLIC HEALTH NURSE Phone #: 617-846-1740 ext 130

Vaccine Name: * (Circle)	Vaccine Manufacturer:	Vaccine Lot Number:	Date Vaccine Administered:*	Vaccine Type: * (Circle)	Injection Site: * (Circle)	Injection Route: * (Circle)
H1N1			(MM/DD/YY)	Dose #1	Right Arm	Intramuscular
				Dose #2	Left Arm Right Leg Left Leg	Intranasal

Clinic Site Name: WINTHROP HEALTH DEPARTMENT Site PIN# : 11812
 Clinic Address: 5 METCALF SQUARE, WINTHROP, MA 02152 Vaccine Administrator: _____
 Date Vaccine Information Statement (VIS) given: _____ Date on VIS: _____
 Signature of Vaccine Administrator: _____ Date: _____