

# H1N1 CONSENT FORM CAPE ELIZABETH SCHOOLS

**PRINT CLEARLY.** Physicians Name \_\_\_\_\_ Children ages 6 months to 18 years

LAST NAME:		FIRST /NAME:				MIDDLE:	
ADDRESS:				CITY:		STATE:	ZIP:
BIRTH DATE:	AGE:	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		PHONE # where you can be reached the day of the clinic:			

**Insurance Information**

Name of Insurer:													
Enter Insurance ID #													

**SCREENING TOOL**

	YES	NO
<input type="checkbox"/> Has your child ever had a severe reaction to a previous vaccination?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Is your child allergic to eggs?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Does your child have a past history of Guillain-Barre Syndrome?	<input type="checkbox"/>	<input type="checkbox"/>
<b><input type="checkbox"/> STOP: If you answered yes to any of the above questions, your child cannot receive H1N1 vaccine at school. Contact your physician.</b>		
<input type="checkbox"/> Does your child have asthma, lung disease, heart disease, diabetes, kidney problems, a blood disorder, immunodeficiency disease or are receiving aspirin or immunosuppressive therapies? Please explain:	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Is your child pregnant or nursing? (Older students only)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Does your child have close contact with a person who needs care in a protected environment (for example, someone who recently had a bone marrow transplant)?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Has your child received any other vaccinations in the past 30 days? Vaccine _____ Date _____	<input type="checkbox"/>	<input type="checkbox"/>
<b><input type="checkbox"/> If you answered yes to any of the above 4 questions, your child will need a shot and should not get FluMist.</b>		
<b>Children aged 9 and under will require 2 doses of H1N1, 4 weeks apart.</b>		

I have been provided a copy of the 2009 H1N1 Vaccine Information Sheets and had the opportunity to ask questions. I understand the benefits and risks of the influenza vaccine as described and ask that it be given to my child. I understand that if I consent to both types of the 2009 H1N1 vaccine, my child will be given the most appropriate vaccine, as determined by the health care provider giving the vaccination. I acknowledge that no guarantees have been made concerning the results of the vaccine. I hold harmless, HomeHealth Visiting Nurses its employees, and the facility in which the vaccine was received. I request that payment of authorized benefits be made on my behalf directly to HomeHealth Visiting Nurses.

X \_\_\_\_\_ Date \_\_\_\_\_  
Parent or guardian signature

**STAFF USE ONLY BELOW THIS LINE**

VACCINE: circle: FluMist Sanofi EXPIRES: \_\_\_\_\_ NURSE'S SIGNATURE: \_\_\_\_\_  
 DATE:     /     /09 Lot # \_\_\_\_\_ Dose: 0.5ml  
 Deltoid injection site :  Left  Right Dose # (1<sup>st</sup> 2<sup>nd</sup> )