

**OZAUKEE COUNTY PUBLIC HEALTH DEPARTMENT  
2009 H1N1 FLU VACCINE CONSENT FORM**

Information collected on this form will be used to document permission for your child to receive the 2009 H1N1 influenza vaccine at your child's school. Record of this immunization may be shared through the Wisconsin Immunization Registry (WIR) with other health care providers directly involved with your child's care.

**SCHOOL:** \_\_\_\_\_ **City:** \_\_\_\_\_

Student's Name (Last, First, Middle initial)			Gender: Male Female		
Student's Birthdate Month _____ Day _____ Year _____	Student's Age	School Grade	Parent/Guardian Daytime Phone Number ( )		
Home Address	P. O. Box	City	County	State	Zip Code
Parent/Guardian's Name		Okay to share H1N1 immunization data with the Wisconsin Immunization Registry (WIR)? Yes No			

**Please answer the following questions (circle Yes or No):**

1. Does your child have a serious allergy to eggs?	YES	NO
2. Does your child have any other serious allergies? Please list _____	YES	NO
3. Has your child ever had a serious reaction or allergic response to past flu vaccinations?	YES	NO
4. Has your child ever had Guillian Barré syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	YES	NO

**There are two types of 2009 H1N1 influenza vaccine (Shot or Nasal Spray). Your answers to the following questions will help us know which of the two kinds of vaccine your child can receive.**

5. Has your child been vaccinated with any vaccine (including H1N1) within the past 4 weeks? (for example, nasal spray influenza, MMR, Varicella, etc)? List Vaccine(s): _____ Date received: _____	YES	NO
6. 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?	YES	NO
7. Is your child on long-term aspirin or aspirin-containing therapy (for example, does your child take aspirin every day)?	YES	NO
8. Does your child have a weakened immune system (for example, from HIV, cancer, or medications such as steroids)?	YES	NO
9. Is your child pregnant? or, breastfeeding?	YES	NO
10. Does your child have close contact with a person whose immune system is severely compromised and who must be in a protective isolation (such as in a hospital room with reverse air flow)?	YES	NO

**CONSENT FOR VACCINATION:** I have read, or have had explained to me, the 2009 Vaccine Information Statement for 2009 H1N1 influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine be given the person named above for whom I am authorized to make this request.  H1N1 Injectable or  H1N1 Nasal Spray or  either is acceptable (based on eligibility and availability)

Signature X \_\_\_\_\_ Date \_\_\_\_\_

**DECLINED CONSENT FOR VACCINATION:** I have read, or have had explained to me, the 2009 Vaccine Information Statement for 2009 H1N1 influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine **NOT** be given the person named above for whom I am authorized to make this request.

Signature X \_\_\_\_\_ Date \_\_\_\_\_

**BELOW IS FOR ADMINISTRATIVE USE ONLY**

Vaccine	Date Dose Administered	Route	Dose Number	Vaccine Mfg	Lot Number	Name and Title of Interviewer
2009 H1N1	/ /	<input type="checkbox"/> IM	1			
		<input type="checkbox"/> RD <input type="checkbox"/> LD <input type="checkbox"/> RV <input type="checkbox"/> LV <input type="checkbox"/> Intranasal	2			
						Name and Title of Vaccine Administrator