2009 Pediatric H1N1 Influenza Vaccine Consent Form

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

CHILD'S NAME (Last)	(First)	(M.I.)	**CHILD'S DATE OF BIRTH** **month_________ day________ year __________**	
PARENT/LEGAL GUARDIAN'S NAME (Last)	(First)	(M.I.)	**CHILD'S AGE**	**CHILD'S GENDER** **M / F**
ADDRESS			**PARENT/GUARDIAN DAYTIME PHONE NUMBER:** ________________________________	
CITY	**STATE**	**ZIP**	**CHILD'S SS #**	

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 may be able to get the 2009 H1N1 vaccine, but we will 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 after receiving a flu vaccine?	☐	☐

B. There are two kinds of 2009 H1N1 influenza vaccine. Your answers to the following questions will help us know which of the two kinds of vaccine your child can get.

	YES	NO
1. Has your child gotten vaccinated with any vaccine (not just flu) within the past 30 days? Vaccine: __________________________________ Date given: month______day_______year___________	☐	☐
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?	☐	☐
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)?	☐	☐

Section 3: Consent

CONSENT FOR CHILD'S VACCINATION: I give permission for my child to receive: ☐ Intranasal H1N1 Vaccine ☐ Injectable vaccine ☐ Either

I have received, read, and understand the Novel H1N1 Vaccine Information Statement (VIS). I have had a chance to ask questions and discuss my concerns with a healthcare professional. I give permission to the Collier County Health Department to give my child the H1N1 vaccine marked above.

I ____ , (please print name of consenting adult), have the following relation with the child named above (please check relationship to child).

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

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 administration for the child named above.

Print Name____

Signature of Parent/Legal Guardian _________________________________ Date___________________________________

PLEASE COMPLETE THIS FORM IF YOU HAVE MEDICARE, MEDICAID OR PRIVATE INSURANCE

Insurance Company Name: ____

Insurance Telephone Number (____) ______________________________

Insurance Address ____

City _________________St_______ Zip _____________

Insurance Identification Number: _______________________Group Number: _____________

Name of Insured: ____

Date of Birth of Insured: Month ______ Day _________ Year____________

Relationship to Insured _____ Self _____Spouse _____ Child _____ Dependent

I certify the information given by me is correct to the best of my ability. I authorize any holder of medical or other information about me to release the Social Security Administration or it intermediaries or carriers any information needed for this claim. I permit a copy of this authorization to be used in place of the original. I request that payment of authorized benefits be made on my behalf. I assigned the benefits payable for these services to the organization furnishing the service or authorize such physician or organization to submit a claim to Medicare for payment by me. I have also received a copy of the Notice of Privacy Practices.

Signature: ____ Date______________________

Section 4: Vaccination Record

FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Dose Administered	Route	Site	Dose Number (1st or 2nd)	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator
2009 H1N1		☐ IM ☐ Intranasal	☐ RDT ☐ LDT				
2009 H1N1		☐ IM ☐ Intranasal	☐ RDT ☐ LDT				

VIS Date 10-2-09

Date VIS Given _________________