

**Gorham Schools
H1N1 Flu Consent
Form**

PRINT CLEARLY. Physicians Name _____ Tel# _____ MD Address _____

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
▪ Has your child ever had a severe reaction to a previous seasonal or H1N1 vaccine influenza vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
Is your child allergic to eggs, chicken, gentamicin, gelatin, or arginine?	<input type="checkbox"/>	<input type="checkbox"/>
▪ Does your child have a past history of Guillain-Barre Syndrome?	<input type="checkbox"/>	<input type="checkbox"/>
▪ Is your child sick with a fever? Child's body temperature taken by the nurse day of clinic:	<input type="checkbox"/>	<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.		
▪ Does your child have asthma, lung disease, heart disease, diabetes, kidney problems, a blood disorder, immunodeficiency disease or are receiving aspirin or immunosuppressive therapies?	<input type="checkbox"/>	<input type="checkbox"/>
▪ Is your child pregnant or nursing? (Older students only)	<input type="checkbox"/>	<input type="checkbox"/>
▪ Is your child in close contact with anyone who has a severely weakened immune system? (These people require care in a protected environment.)	<input type="checkbox"/>	<input type="checkbox"/>
▪ Has your child received any other vaccinations in the past 4 weeks? If child received MMR, Varicella or FluMist, they will require a flu shot. Date of vaccinations:	<input type="checkbox"/>	<input type="checkbox"/>
▪ If you answered yes to any of the above 3 questions, your child will need a shot and should not get FluMist.		
▪ I give permission for my child to receive intranasal H1N1 vaccine if appropriate.	<input type="checkbox"/>	<input type="checkbox"/>
▪ I give permission for my child to receive injected H1N1 influenza vaccine.	<input type="checkbox"/>	<input type="checkbox"/>
Children aged 9 and under will require 2 doses of H1N1, 4 weeks apart.		

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.

I give permission for this form to be copied and sent to my child's primary care provider.

My child may eat a snack provided by the school after the vaccine is administered : yes no

X _____ Date _____

Parent or guardian signature

STAFF USE ONLY BELOW THIS LINE

VACCINE: circle: H1N1 FluMist Sanofi **EXPIRES:** _____ **NURSE'S SIGNATURE:** _____

DATE: / /09 **Lot #** _____ **Dose:** 0.5ml Deltoid injection site: Left Right **Dose#** 1st, 2nd

