HEALTH SCREEN: PLEASE RETURN THIS FORM BY FRIDAY, OCTOBER 23, 2009

STUDENT NAME:________________________________ SCHOOL NAME: ________

BIRTHDATE ___________ AGE: ___ GRADE IN SCHOOL: _____

ADDRESS: ____ CITY:________________

TELEPHONE: ________________ **Phone number where you can be reached day of clinic:** _____________

**** The following questions will help us determine if there is any reason your child should not receive the H1N1 influenza vaccination on clinic day. <u>Please answer every question.</u>**

1.) Does your child have an allergy to eggs? YES NO

2.) Does your child have any other serious allergies that you know of? (please list) YES NO

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3.) Has your child ever had a LIFE THREATENING reaction to immunizations in the past? YES NO

4.) Has your child ever had Guillain-Barre Syndrome? YES NO

**** 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.**

1.) Has your child been vaccinated with any vaccine (not just flu) within the past 30 days? YES NO
Vaccine: _________________________________ Date given: month_____ day____ year______

2.) Does your child have asthma? YES NO

3.) Does your child have any of the following: **diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood? (Circle all that apply.)** YES NO

4.) Is your child taking aspirin on a regular basis? YES NO

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)? YES NO

6.) Could your child be pregnant? (for 6th graders and older) YES NO

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)? YES NO

8.) Does your child have seizures? YES NO

9.) Does your child have cerebral palsy? YES NO

I give permission for this form to be sent to my child's primary care provider YES NO

Health Insurance Company (if any) and Number: ______________________________________

Name of child's health care provider (doctor, nurse practitioner): ___________________________

Phone number of child's health care provider: ___________________

FOR OFFICE USE ONLY:

Vaccine	Date Dose Administered	Route	Dose Number (1st or 2nd)	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator
2009 H1N1	/ /	☐ IM ☐ Intranasal				
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H1N1 Influenza Vaccine Permission Form

I was given a copy of the 2009 H1N1 Vaccine Information Statements and I have read it or had it explained to me. I understand the benefits and the risks of the 2009 H1N1 Influenza Vaccination **and ask that the vaccine be given to my child.** I understand that if I consent to both types of vaccine, my child will be given the most appropriate vaccine, as determined by the health care provider giving the vaccination

I give permission for my child to receive intranasal H1N1 influenza vaccine if appropriate. ☐ yes ☐ no

I give permission for my child to receive injected H1N1 influenza vaccine. ☐ yes ☐ no

Signature of Parent or Guardian:______________________________________ Date:______________

Parent or Guardian Name (please print): ____

Please be sure to complete the reverse side of this sheet – Health Screen.