

**Portage County Local Health Departments  
2009 H1N1 Flu Shot**

**School Consent Form-2<sup>nd</sup> Dose**

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

STUDENT'S NAME (Last)			(First)	(M.I.)	STUDENT'S DATE OF BIRTH month                      day                      year	
PARENT/LEGAL GUARDIAN'S NAME (Last)			(First)	(M.I.)	STUDENT'S AGE	STUDENT'S GENDER M / F
ADDRESS					PARENT/GUARDIAN DAYTIME PHONE NUMBER:	
CITY	STATE	ZIP				
SCHOOL NAME					GRADE	

**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

The following questions will help us know if your child can get the 2009 H1N1 influenza vaccine. Please mark YES or NO for each question.

	YES	NO
1. Does your child have a serious allergy to eggs?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your child have any other serious allergies that cause anaphylaxis that you know of? Please list: _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Has your child ever had a serious reaction to a previous dose of flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>

**Section 3: Consent**

**CONSENT FOR CHILD'S VACCINATION:**

I have read or had explained to me the 2009-2010 Vaccine Information Statement for the 2009 H1N1 influenza vaccine and understand the risks and benefits.

**I GIVE CONSENT** to the STATE/LOCAL health department and its staff for my child named at the top of this form to get vaccinated with this vaccine. **(If this consent form is not signed, dated, and returned, then your child will not be vaccinated at school.)**

Signature of Parent/Legal Guardian \_\_\_\_\_

Date: month \_\_\_\_\_ day \_\_\_\_\_ year \_\_\_\_\_

**Section 4: Vaccination Record**

FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Dose Administered	Route	Dose Number 2nd	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator
2009 H1N1	/ /	IM				