



State of New Hampshire 2009 H1N1 Influenza Vaccine Registration and Consent Form School Based Clinics



Information about child to receive vaccine (please print)

LAST NAME		FIRST NAME		MI
ADDRESS		CITY	STATE	ZIP
PARENT/GUARDIAN HOME PHONE	PARENT/GUARDIAN OTHER PHONE	DATE OF BIRTH		AGE
()	()	/ /		

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 injection
- Dose 2 Date received: month ____ day ____ year ____ Form (please circle): nasal spray injection

The following questions will help us determine if your child can received 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 you know of? If yes, 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"/>
5. Has your child been vaccinated with any vaccine (not just flu) within the past 30 days? Vaccine _____ Date given: _____ (m/d/yr)	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
7. Is your child on long-term aspirin or aspirin-containing therapy (for example, does your child take aspirin every day)?	<input type="checkbox"/>	<input type="checkbox"/>
8. Does your child have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer), or is your child pregnant?	<input type="checkbox"/>	<input type="checkbox"/>

Consent for Child's Vaccination

I have read or have had explained to me the Vaccine Information Statement (VIS) on 2009 H1N1 Influenza Vaccine. I give my consent for my child, named at the top of this form to be vaccinated with this vaccine. I understand that if I sign below I am giving consent and my child will be given the most appropriate vaccine as determined by the health care provider giving the vaccine.

SIGNATURE OF PARENT/ LEGAL GUARDIAN	DATE



State of New Hampshire 2009 H1N1 Influenza Vaccine Registration and Consent Form School Based Clinics



CLINIC USE ONLY	Dose: <input type="checkbox"/> First <input type="checkbox"/> Second <input type="checkbox"/> Unknown	Age Categories: <input type="checkbox"/> 6-23 mos <input type="checkbox"/> 24-59 mos <input type="checkbox"/> 5-18 yrs				
2009 H1N1 VACCINE <small>CHECK BOX</small>	MANUFACTURER <small>CIRCLE</small>	LOT #/ EXP DATE <small>FILL IN</small>	DOSE <small>CIRCLE</small>	ROUTE <small>CIRCLE</small>	SITE <small>CIRCLE</small>	CDC VIS <small>CIRCLE</small>
<input type="checkbox"/> MULTI DOSE VIAL	SANOFI-PASTEUR		0.25ML	IM	RT LT	10/02/2009
	NOVARTIS		0.5ML			
	CSL					
<input type="checkbox"/> SINGLE DOSE SYRINGE, PEDIATRIC	SANOFI-PASTEUR		0.25 ML		RD LD	
<input type="checkbox"/> SINGLE DOSE SYRINGE, ADULT	SANOFI-PASTEUR NOVARTIS CSL		0.5 ML			
<input type="checkbox"/> SINGLE DOSE INTRANASAL SPRAYER	MEDIIMUNE		0.2 ML	INTRANASAL		
SIGNATURE OF VACCINE ADMINISTRATOR					DATE	