34340

Colorado 2009-2010 H1N1 Flu Vaccine Consent and Screening Form

Child/Student

Please print neatly in capital letters as shown in the example: EXAMPLE 123

Please shade circles completely Correct: ● Incorrect: ⊗ ✓

Please use reverse side for notes

Personal Information: Provide information as completely as you can. All information will be kept confidential.

Child / Student First Name | **Child / Student Last Name** | **MI**

Street No. or PO Box | **Street Name** | **Apt. Number**

City | **County** | **State** | **Zip Code** | **Gender** ○ M ○ F

Health Insurance: ○ Medicaid ○ Medicare ○ Kaiser Permanente ○ Other Private ○ No Insurance

Insurance Policy Number

School Name: | **Grade:** | **Date of Birth:** M M / D D / Y Y Y Y

Parent First Name | **Parent Last Name** | **Parent Daytime Phone Number:** - -

If your child has already been vaccinated with 2009 H1N1 influenza, please tell us the number of doses and dates of vaccination.

Dose 1 received: ○ nasal spray ○ shot — M M / D D / Y Y Y Y

Dose 2 received: ○ nasal spray ○ shot — M M / D D / Y Y Y Y

1. Does your child have a serious allergy to eggs or to a component of the flu vaccine? ○ YES ○ NO
2. Has your child ever had a serious reaction to a previous dose of flu vaccine? ○ YES ○ NO
3. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness)? ○ YES ○ NO
4. Has your child received any vaccine within the past 30 days? ○ YES ○ NO
5. Is your child on long-term aspirin or aspirin-containing therapy? ○ YES ○ NO
6. Is your child pregnant? ○ YES ○ NO
7. Does your child have close contact with a person who has a weakened immune system? ○ YES ○ NO
8. Does your child have any of the following illnesses or conditions? ○ YES ○ NO
   Chronic lung disease (including asthma), heart disease, diabetes, brain, spinal cord or muscle illness that causes swallowing or lung problems, problems with the immune system caused by medications and/or HIV, kidney disease, liver disease, blood disorders

CONSENT FOR VACCINATION:

I have read or had explained to me the Vaccine Information Statement (10/02/2009) for the 2009 H1N1 Influenza Vaccine and understand the risks and benefits of receiving the vaccine. I have had a chance to ask questions, which were answered to my satisfaction. I hereby release this provider, its employees and its volunteers from any liability for any results which may occur from the administration of this vaccine.

○ I give consent ○ I do not give consent for my child named at the top of this form to be vaccinated with this vaccine.

Signature of Parent/Legal Guardian: _____ **Date:** _____

STOP - DO NOT WRITE BELOW THIS LINE

H1N1-2009 VIS	Manufacturer	Dosage	Site	Administered By:
10/02/2009	○ SP ○ GSK ○ NOV ○ MI ○ CLS	○ 0.20 mL ○ 0.25 mL ○ 0.50 mL	○ RD ○ RT ○ LD ○ LT ○ Intranasal	Name: Title:

Lot No.

H1N1 PIN: 0148

Provider Name: Jeffco Health

Provider Type: ● Public ○ Private

Date Administered: M M / D D / Y Y Y Y

10/14/2009

For Persons Under 18 yrs

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