# Cooper County Public Health Center 2009 H1N1 Influenza Vaccine School Consent Form

**(Injection or Nasal Spray)**

**Information about Child to Receive Vaccine (Please Print)**

| **STUDENT'S NAME** (Last) | (First) | (M.I.) | **STUDENT'S DATE OF BIRTH** **Month_________ Day________ Year __________** | |
|---|---|---|---|---|
| **MOTHERS MAIDEN NAME** (LAST) | | | **STUDENT'S AGE** | **STUDENT'S GENDER** **M / F** |
| **ADDRESS** | | | | |
| **CITY** | **STATE** | **ZIP** | **PARENT/GUARDIAN DAYTIME PHONE NUMBER:** | |
| **SCHOOL NAME** | | | **GRADE** | |

Optional: Race ___Amer. Indian/Alaska native, ____Asian, ___Black, ___Native American or Pacific Islander, ___White,
Ethnicity: ____Hispanic or Latino, ___Non-Hispanic or Latino

## Screening for Vaccine Eligibility

| **The answers to the following questions will help us determine 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? | ☐ | ☐ |
| 2. Does your child have any other serious allergies? Please list: ____________________________________________ | ☐ | ☐ |
| 3. Has your child ever had a serious reaction to a previous dose of influenza vaccine? | ☐ | ☐ |
| 4. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness)? | ☐ | ☐ |

| **Your answers to the following questions will help us know which type of vaccine your child can get (Injection or Nasal Spray).** | **YES** | **NO** |
|---|---|---|
| 1. Has your child gotten vaccinated with any vaccine (not just flu) within the past 30 days? Vaccine: ____________________________________ Date given: Month______Day_______Year____________ | ☐ | ☐ |
| 2. 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? | ☐ | ☐ |
| 3. Is your child on long-term aspirin or aspirin-containing therapy? (For example, does your child take aspirin every day) | ☐ | ☐ |
| 4. Does your child have a weak immune system? (For example, from HIV, cancer, or medications such as steroids or those used to treat cancer)? | ☐ | ☐ |
| 5. Is your child pregnant? | ☐ | ☐ |
| 6. Does your child visit a hospitalized person who needs care in a protected environment? (For example, a hospitalized person who has had a bone marrow transplant) | ☐ | ☐ |
| **If your child is started on an Antiviral medication before the scheduled school vaccination clinic, please contact: ___________** | | |

**If you have answered no to all of the above questions, your child qualifies for either type of vaccine. Which would you prefer?**

**____Injection (Shot) ____Nasal Spray**

**If no preference is indicated, your child will receive vaccine based on availability.**

**CONSENT FOR CHILD'S VACCINATION:**

Signature:

I have been given a copy and have read, or had explained to me, the information in the "Vaccine Information Statement(s)," where applicable, for the vaccine(s) indicated below. I have had a chance to ask questions and had them answered to my satisfaction. I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine(s) currently due for which I have signed below be given to me or to the person named above for whom I am authorized pursuant to Section 431.058, RSMo to make this request.

Note: The vaccine for H1N1 has been declared a covered countermeasure under the Public Readiness and Emergency Preparedness Act (42 U.S.C. § 247d-6d).

I understand that student immunization records are a legal requirement in each state for a student to attend a public school. Family Educational Rights and Privacy Act (FERPA) currently include the student's immunization record as part of his or her education record. This information is not always added to the Missouri immunization information system (IIS). Under current FERPA regulations, schools are not permitted to update Missouri's IIS system without individual consent. Such consent may be parental or from a child over 18 years of age. This restriction may result in over-immunization of students, increased administrative burdens, increased difficulty enrolling children into school, and the inability of public health to prevent vaccine-preventable diseases. Therefore, I confirm my consent to submit the information captured on this form to be entered into Missouri's immunization information system. I understand that I may elect not to have my information entered into Missouri's IIS by selecting the check box below.

❑

**Back side for administrative use.**

FOR ADMINISTRATIVE USE ONLY

| Vaccine | Date Dose Administered | Route | Dose | Injection Site | Vaccine Manufacturer | Lot Number |
|---|---|---|---|---|---|---|
| 2009 H1N1 | / / | ☐ IM<br>☐ Intranasal | ☐ 0.25 ml ☐ 0.5 ml<br>☐ 0.2 ml | | | |
| Name and Title of Vaccine Administrator | | | | | | |