NORTHERN KENTUCKY INDEPENDENT DISTRICT HEALTH DEPARTMENT

CONSENT FORM

H1N1 Influenza Vaccine ADMINISTRATION RECORD Offsite Location:_____

CHILD'S NAME: _____ **SOCIAL SECURITY#:** _____

ADDRESS: _____
STREET CITY COUNTY STATE ZIP

BIRTHDATE: _____/_____/_____ **PHONE NUMBER:** _____
MONTH DAY YEAR

RACE: (Check ONE or MORE) ☐ **(W)** White ☐ **(B)** Black or African American ☐ **(N)** American Indian or Alaska Native
☐ **(A)** Asian ☐ **(H)** Native Hawaiian or Other Pacific Islander **ETHNICITY:** Hispanic or Latino **(Y)** Yes or **(N)** No

GENDER: (Check ONE) ☐ Male ☐ Female

Y	N	
☐	☐	Has your child had a previous H1N1 vaccine? ____ Nasal ____ Shot DATE:_____
☐	☐	Does your child have a serious allergy to eggs?
☐	☐	Does your child have any other serious food or drug allergies? Please list_____
☐	☐	Has your child ever had a serious reaction to a previous dose of flu vaccine?
☐	☐	Has your child ever had Guillain-Barre Syndrome (temporary severe muscle weakness) within 6 weeks after receiving a flu shot?
☐	☐	Has your child gotten vaccinated with any vaccine (not just flu) within the past 30 days? Vaccine_____ Date_____
☐	☐	Does your child have any of the following: asthma, diabetes, disease of the lungs, heart, kidneys, liver, nerves, or blood?
☐	☐	Is your child on long-term aspirin or medication containing aspirin (does your child take aspirin every day)?
☐	☐	Does your child have a weak immune system (HIV, cancer, or medications, such as steroids or those used to treat cancer)?
☐	☐	Is your child pregnant?
☐	☐	Does your child have close contact with a person who needs care in a protected environment (example, someone who has recently had a bone marrow transplant)?

The health department may keep this record in a medical file. They will record what vaccine was given, when the vaccine was given, the name of the company that made the vaccine, the vaccine's special lot number, the vaccine injection site, the signature and title of the person who gave the vaccine, and the address where the vaccine was given.

"I have read or have had explained to me the 2009-2010 Vaccine Information Statement (VIS) and understand the risks and benefits for the: (Check one box)

( ) **2009-2010** *Inactivated* ***H1N1 influenza vaccine, (VIS dated 10/2/09)***
( ) **2009-2010** *Live,* ***Intranasal H1N1 influenza vaccine, (VIS dated 10/2/09)***

X_____ **DATE:** _____
Signature of Parent or Legal Guardian of child receiving H1N1 vaccine

FOR HEALTH DEPARTMENT USE ONLY

Vaccine Manufacturer:_____ Vaccine Lot Number:_____

Injection Site: _____

Signature and Title of Provider: _____ Provider#:_____

NOTES: _____

Dose # 1 _____ **Dose #2** _____