

2009 H1N1 FLU VACCINE CONSENT FORM

Information collected on this form will be used to document permission for your child to receive the 2009 H1N1 influenza vaccine at your child's school. Record of this immunization may be shared through the Wisconsin Immunization Registry (WIR) with other health care providers directly involved with your child's care.

SCHOOL: _____ **City:** _____

Student's Name (Last, First, Middle initial)			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Age _____
Student's Birthdate Month _____ Day _____ Year _____		Student's Age	School Grade		Parent/Guardian Daytime Phone Number () _____
Home Address	P. O. Box	City	County	State	Zip Code
Parent/Guardian's Name		Okay to share H1N1 immunization data with the Wisconsin Immunization Registry (WIR)? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Please answer the following questions (circle Yes or No):

1. Does your child have a serious allergy to eggs?	YES	NO
2. Does your child have any other serious allergies? Please list _____	YES	NO
3. Has your child ever had a serious reaction or allergic response to past flu vaccinations?	YES	NO
4. Has your child ever had Guillian Barré syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	YES	NO

CONSENT FOR CHILD'S VACCINATION:

I have read, or have had explained to me, the 2009 Vaccine Information Statement for 2009 H1N1 influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine requested and ask that the vaccine be given to the student named above for whom I am authorized to make this request.

Signature X _____ Date _____

FOR OFFICE USE VIS date: 10/02/009
2009 H1N1: Route (circle one) = IM Body site (circle one) = RD or LD Dose (circle one): 1 or 2
Manufacturer _____ Lot No. _____
Signature and title of person administering vaccine: _____
Date vaccine administered: _____