



34340

Colorado 2009-2010 H1N1 Flu Vaccine Consent and Screening Form



Child/Student

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

E	X	A	M	P	L	E	1	2	3
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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	
																									<input type="radio"/> M <input type="radio"/> F	

Health Insurance:															Insurance Policy Number				
<input type="radio"/> Medicaid <input type="radio"/> Medicare <input type="radio"/> Kaiser Permanente <input type="radio"/> Other Private <input type="radio"/> No Insurance																			

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:					Dose 2 received:									
<input type="radio"/> nasal spray <input type="radio"/> shot					<input type="radio"/> nasal spray <input type="radio"/> shot									
M M / D D / Y Y Y Y					M M / D D / Y Y Y Y									

- Does your child have a serious allergy to eggs or to a component of the flu vaccine? YES NO
- Has your child ever had a serious reaction to a previous dose of flu vaccine? YES NO
- Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness)? YES NO
- Has your child received any vaccine within the past 30 days? YES NO
- Is your child on long-term aspirin or aspirin-containing therapy? YES NO
- Is your child pregnant? YES NO
- Does your child have close contact with a person who has a weakened immune system? YES NO
- 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 <input type="radio"/> RD <input type="radio"/> RT <input type="radio"/> LD <input type="radio"/> LT <input type="radio"/> Intranasal					Administered By:	
10/02/2009		<input type="radio"/> SP <input type="radio"/> GSK <input type="radio"/> NOV <input type="radio"/> MI <input type="radio"/> CLS			<input type="radio"/> 0.20 mL <input type="radio"/> 0.25 mL <input type="radio"/> 0.50 mL		Lot No. _____					Name:	
												Title:	

H1N1 PIN:				Provider Name:										Date Administered:				
0 1 1 2				B r o o m f i e l d H H S I										M M / D D / Y Y Y Y				
				Provider Type: <input checked="" type="radio"/> Public <input type="radio"/> Private														

10/14/2009

For Persons Under 18 yrs

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