

**Polk County Health Department
2009 H1N1 Influenza Vaccine Consent Form**



Please provide child's information (please print)

STUDENT'S NAME (Last)		(First)	(M.I.)	STUDENT'S DATE OF BIRTH (month) _____ (day) _____ (year) _____	
PARENT/LEGAL GUARDIAN'S NAME (Last)		(First)	(M.I.)	STUDENT'S AGE	STUDENT'S GENDER M / F
ADDRESS			PARENT / GUARDIAN DAYTIME PHONE NUMBER:		
CITY	STATE	ZIP			
SCHOOL NAME			STUDENT ID	GRADE	

Please circle your answer:

- Did the child already have the 2009 H1N1 Influenza shot or flu nose spray? Yes or No
- Has your child had any vaccines within the past month? Yes or No If yes, what kind: _____
- Does your child have an allergy to eggs? Yes or No
- Does your child have any other allergies that you know of? Yes or No If yes, please list: _____
- Has your child ever had a reaction to a previous dose of flu vaccine? Yes or No If yes, what kind: _____
- Does your child have any health problems? Yes or No If yes, please list: _____
(such as heart disease, lung disease, asthma, kidney disease, neurologic or neuro-muscular disease, liver disease, diabetes or anemia or another blood disorder)
- Is your child pregnant? Yes or No
- Have you read the 2009 – 2010 Vaccine Information Statement (tan handout) for the 2009 H1N1 Influenza (Swine flu) vaccine and understand the risk and benefits? Yes or No
- Do you want your child vaccinated with the Swine Flu nose spray (no needle)? . . If yes, sign form below and return.

Note: Children 9 years old and younger get the first dose now and then the second dose after 30 days.

No Needle



Swine Flu Nose Spray
Note: Child with pregnancy, athsma, diabetes or weak immunity Cannot get the flu nose spray

For H1N1 vaccination questions/concerns call (863) 534 - 7277.

Please provide the best phone number in case we need to reach you: _____

I understand the information about the vaccine and give permission to the Polk County Health Department staff for my child to get vaccinated.

Signature of Parent/Legal Guardian _____

Today's date: _____

Printed Name of Parent/Legal Guardian _____

(month) (day) (year)

* Note to School: Please verify that this information matches the student's information on file.

For use by Health Department only.

Heath Department Use Only	Route	Dose Number (1st or 2nd)	Vaccine Manufacturer	Lot Number	Date Dose Administered	Name and Title of Vaccine Administrator
2009 H1N1					/ /	