

**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 or blue handout) for the 2009 H1N1 Influenza (Swine flu) vaccine and understand the risk and benefits? Yes or No
- Which type of vaccine would you like your child to receive? Mark **one** box to choose either nose spray **or** shot


No Needle



Swine Flu Nose Spray

Note: Child with pregnancy, asthma, diabetes or weak immunity **Cannot** get the flu nose spray

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



Shot (Needle)

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

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

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)

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