34340

Colorado 2009-2010 H1N1 Flu Vaccine Consent and Screening Form

Child/Student

Please print neatly in capital letters as shown in the example: EXAMPLE 123

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** O M O F

Health Insurance:
O Medicaid O Medicare O Kaiser Permanente O Other Private O No Insurance

Insurance Policy Number

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: O nasal spray O shot — M M / D D / Y Y Y Y

Dose 2 received: O nasal spray O shot — M M / D D / Y Y Y Y

1. Does your child have a serious allergy to eggs or to a component of the flu vaccine?	O YES O NO
2. Has your child ever had a serious reaction to a previous dose of flu vaccine?	O YES O NO
3. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness)?	O YES O NO
4. Has your child received any vaccine within the past 30 days?	O YES O NO
5. Is your child on long-term aspirin or aspirin-containing therapy?	O YES O NO
6. Is your child pregnant?	O YES O NO
7. Does your child have close contact with a person who has a weakened immune system?	O YES O NO
8. Does your child have any of the following illnesses or conditions? 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	O YES O NO

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.

O I give consent O 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	Administered By:
10/02/2009	O SP O GSK O NOV O MI O CLS	O 0.20 mL O 0.25 mL O 0.50 mL	O RD O RT O LD O LT O Intranasal	Name: Title:

Lot No.

H1N1 PIN: 0112

Provider Name: Broomfield HHSI

Provider Type: ● Public O Private

Date Administered: M M / D D / Y Y Y Y

10/14/2009

For Persons Under 18 yrs

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