

Section 1: Information about Child to Receive Vaccine (please print)

NAME (Last)		(First)	(M.I.)	Child's DATE OF BIRTH / /	
PARENT/LEGAL GUARDIAN'S NAME (Last)		(First)	(M.I.)	AGE	GENDER M / F
ADDRESS			PARENT/GUARDIAN DAYTIME PHONE NUMBER:		
CITY	STATE	ZIP			
SCHOOL NAME			GRADE		

Section 2: Screening for Vaccine Eligibility

If your child has already been vaccinated with 2009 H1N1 flu vaccine, please tell us the number of doses and dates of vaccination.

<input type="checkbox"/> Dose 1	Date received: month ___ day ___ year ____	Form (please circle):	nasal spray	shot
<input type="checkbox"/> Dose 2	Date received: month ___ day ___ year ____	Form (please circle):	nasal spray	shot

The following questions will help us know if your child can get the 2009 H1N1 flu vaccine. Please mark YES or NO for each question.

If you answer "YES" to one or more of the four questions, your child will not be able to receive the 2009 H1N1 flu vaccine in school unless there is a note from your child's health care provider approving the vaccination. If you answer "NO" to the following questions your child will receive the vaccine unless a concern arises following additional screening. If you are not sure of the answers to these questions, please check with your child's healthcare provider.

	YES	NO
1. Does your child have a serious allergy to eggs?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your child have a serious allergy to gentamicin, neomycin, polymixin or gelatin?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has your child ever had a serious reaction to a previous dose of flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>

List other serious allergies: _____

Section 3: Consent

CONSENT FOR CHILD'S VACCINATION:

I have read or had explained to me the 2009-2010 Vaccine Information Statement for the H1N1 flu vaccine and understand the risks and benefits.

I GIVE CONSENT for my child named at the top of this form to get vaccinated with this vaccine. Children younger than 10 years of age need 2 doses of vaccine. (If this consent is not signed, dated and returned, then your child will not be vaccinated.)

Signature of Parent/Legal Guardian

Date: month ___ day ___ year ____

I DO NOT GIVE CONSENT for my child named at the top of this form to get vaccinated with this vaccine.

Signature of Parent/Legal Guardian

Date: month ___ day ___ year ____

PLEASE BE SURE TO READ AND SIGN THE REVERSE SIDE OF THIS FORM

Section 4: Permission to Share Information:

I, _____, give permission to the individual and/or entity that administered the 2009 H1N1 vaccine to my child _____ to share copies of the 2009 H1N1 consent form and vaccination record with my child's school and health care provider named below, as well as with the Massachusetts Department of Public Health and the local board of health in my community. I also give permission for each of these entities to share the 2009 H1N1 consent form and vaccination record with each other.

My child's health care provider:
Name: _____

My child's school:
Name: _____

Address: _____

Grade: _____

- This health information is disclosed at my request and to ensure my child is appropriately vaccinated.
- This permission expires at the end of the 2009-2010 school year.
- If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information received may no longer be protected by federal privacy regulations. State privacy regulations cover information received by the MA Department of Public Health and local boards of health.
- I understand that I may refuse to sign this authorization and that my refusal to sign will **not** affect my child's ability to obtain the vaccination.
- I understand that I may inspect or copy the protected health information to be disclosed under this permission to share.
- Finally, I understand that I may withdraw this permission in writing at any time by sending written notification to:

Town of Uxbridge Board of Health

However, if I withdraw permission at a later date, any vaccine consent form and vaccine record already shared will not be covered by the withdrawal.

Printed name of Parent or Guardian

Signature of Parent or Guardian

Address

Date

2009-2010 Vaccine Administration Record

Information about the person to receive vaccine (please print): *Required Fields

Name: (Last, First, MI)*		DOB: (MM/DD/YY)*	Sex: (Circle)* M F
Address:*			
City:*	State:*	Zip:*	Phone:*()

INSURANCE INFORMATION: *Include the prefix and suffix with the insurance ID number, if applicable.*

Insurance Company:*	Member ID #:*	Group ID #:
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If Patient is not the Subscriber, please complete the following:

Subscriber's Name: (Last, First, MI)*		Subscriber's DOB:	Sex: (Circle)* M F
Subscriber's Address:*(If different from address above)			
City:*	State:*	Zip: *	Phone:*()
Patient Relationship to Subscriber:*(Circle)		Spouse	Child
		Other	

OTHER INSURANCE INFORMATION: *Include the prefix and suffix with the insurance ID number, if applicable.*

Insurance Company:*	Member ID #:*	Group ID #:
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I give permission for my insurance company to be billed.

X _____ Date: _____
(Signature of patient, parent or legal guardian)

For Clinic/Office Use: Contact Person: _____ Phone Number: _____

Vaccine Name:*(Circle)	Vaccine Manufacturer:	Vaccine Lot Number:	Date Vaccine Administered:*	Vaccine Type:*(Circle)	Injection Site:*(Circle)	Injection Route:*(Circle)
H1N1 Seasonal Influenza			(MM/DD/YY)	Dose #1 Dose #2	Right Arm Left Arm Right Leg Left Leg	Intramuscular Intranasal

Clinic Site Name: _____ Site PIN# : _____

Clinic Address: _____ Vaccine Administrator: _____

Date Vaccine Information Statement (VIS) given: _____ Date on VIS: _____

Signature of Vaccine Administrator: _____ Date: _____