

KNOX COUNTY HEALTH DEPARTMENT - School H1N1 Program

Student Consent Form and Live Attenuated H1N1 Vaccine Immunization Nursing Record

****IF YOU DO NOT WANT YOUR CHILD VACCINATED FOR H1N1, DO NOT RETURN THIS FORM.****

PLEASE PRINT

School: _____ Home Room Teacher: _____ Grade: _____ DOB: _____
 Last Name: _____ First Name: _____ Middle Name: _____ Age: _____
 Address: _____ City: _____ Zip Code: _____
 Home Phone: _____ Emergency Contact Number: _____ Gender: (M / F)
 Primary Language: _____ Hispanic: (Y / N) Child's Pediatrician / Physician: _____
 Race: ___White ___Black ___Asian ___American Indian ___Alaskan Native ___Other: _____
 Mother's Last Name: _____ Mother's First Name: _____ MI: _____
 Father's Last Name: _____ Father's First Name: _____ MI: _____
 OR, Guardian, if under 18: Last Name: _____ First Name: _____ Relationship: _____

If you want an H1N1 vaccination given to your child, please CHECK YES or NO to ALL questions below for the STUDENT and sign at the bottom of the form. The Nurse giving the vaccination will review the information on vaccination day.	YES	NO
1. Has your child received a seasonal "FLU" vaccination this year?		
1A. If yes, when did they receive their FLU vaccine? Date Received: / / 2009		
1B. If yes, did they receive the FluMist or the Flu Shot?(please circle answer) FluMist OR Flu Shot		
2. Has your child ever had a reaction to a flu shot? If yes, please describe.		
3. Is your child allergic to vaccine components, i.e. eggs, gentamicin sulfate, MSG? If yes, please describe reaction (redness, swelling, etc.).		
4. Has your child received a vaccine within the past 30 days? Name of Vaccine(s): Date Given:		
5. Does your child have asthma?		
6. Does your child have chronic heart diseases?		
7. Does your child have diabetes or other metabolic diseases/disorders?		
8. Does your child have kidney diseases?		
9. Does your child have blood diseases?		
10. Does your child have close contact with anyone who has had a bone marrow transplant in the last 6 months?		
11. Has your child ever had Guillain-Barre´ syndrome?		
12. Is your child on long-term aspirin therapy?		
13. Does your child have a disease such as cancer, lupus, HIV/AIDS, or do they take a medication that lowers the body's resistance to infection?		
14. Is your child pregnant or nursing?		
Please list any allergies:		
Additional Notes (use back of page if necessary):		

Request for Administration of H1N1 Vaccine for the above named recipient: I am aware that the receiver of this vaccine is currently not pregnant nor will become pregnant within four weeks of receiving this vaccine. I have read information about the vaccine and special precautions on the Vaccine Information Sheet. I have had an opportunity to ask questions regarding the vaccine and understand the risks and benefits. I request and voluntarily consent that the vaccine be given to the person above of whom I am parent or legal guardian and acknowledge that no guarantees have been made concerning the vaccine's success. I hereby release Knox County Government, their affiliates, employees, directors, and officers from any and all liability arising from any accident, act of omission or commission, which arises during vaccination.

This Consent Form is valid for administration of H1N1 vaccinations for six (6) months. It may be used to administer a second dose of H1N1 vaccine, if needed. I understand that I should report any changes of the above information prior to vaccination.

Parent / Guardian Signature

Date

