



Cape May County H1N1 Flu Vaccination Student Consent Form

School Name: _____ Grade _____ Homeroom teacher: _____

Patient Name: _____ DOB: ____/____/____ Age: _____

Parent/legal guardian name (if patient is less than 18 yrs): _____

Home Address: _____ Patient sex: M F

City: _____ State: _____ Zip: _____ Telephone: _____

If you have already been vaccinated with 2009 H1N1 influenza vaccine, please list the number of doses, the dates of vaccination, and the type of vaccine.

Dose 1 Date received: ____/____/____ Type (circle): nasal spray shot
 Dose 2 Date received: ____/____/____ Type (circle): nasal spray shot

If you answer "yes" to any of the following 4 questions, you need a physician's prescription to get a flu vaccine.

- | | | |
|---|------------------------------|-----------------------------|
| 1. Are you allergic to eggs? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2. Have you had a serious allergic reaction to any medications or vaccines? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 3. Have you ever had a serious reaction to the flu vaccine? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 4. Have you ever been told by a physician that you had Guillain-Barré syndrome? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

There are two kinds of 2009 H1N1 influenza vaccine. Your answers to the following questions will help us know which of the two kinds of vaccine you can get.

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Have you been vaccinated with any vaccine (not just flu) within the past 30 days?
Vaccine: _____ Date given: ____/____/____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have any of the following: asthma (including wheezing), diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. If you are less than 18 years of age, are you on long-term aspirin or aspirin-containing therapy? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are you pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)? | <input type="checkbox"/> | <input type="checkbox"/> |

The Cape May County Department of Health is adhering to all federal and state guidelines concerning the administration of the 2009 H1N1 vaccine. I have read or had explained to me the 2009-2010 Vaccine Information Statement for the 2009 H1N1 influenza vaccine. I believe I understand the risks and benefits of the vaccine and I request and consent that it be given to me or to the person above for whom I am authorized to make the request. I hereby release the County of Cape May and the person administering the vaccine from any responsibility for ill effects. By consenting to receive the H1N1 flu vaccine, I also consent to having the vaccine information included in the New Jersey Immunization Information System (NJIIIS) and acknowledge that I may obtain a copy of the vaccination record. If two doses of vaccine are recommended by CDC, I consent that a second dose be administered within the recommended timeframe.

Patient signature, or if less than 18years, signature of the parent or legal guardian:

_____ Date: ____/____/____

For medical use only:

Vaccine	Date Dose Administered	Route/Site	Dose Number (1st or 2nd)	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator
2009 H1N1	/ /	<input type="checkbox"/> IM(L) <input type="checkbox"/> IM(R) <input type="checkbox"/> Intranasal				
2009 H1N1	/ /	<input type="checkbox"/> IM(L) <input type="checkbox"/> IM(R) <input type="checkbox"/> Intranasal				