VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment

Health Department Use ONLY
CI# _____
Encounter # _____

CHILD/ADOLESCENT (LESS THAN 18 YEARS) 2009 H1N1 INFLUENZA VACCINATION CONSENT FORM

SECTION A: STUDENT INFORMATION

Name (Last, First, Middle) :			
Date of Birth: / /	Age:	Gender: ❑ M ❑ F	
School:	Grade:	Home Room Teacher:	

SECTION B: PARENT/GUARDIAN INFORMATION

Name (Last, First, Middle) :			
Address:		City/State:	Zip:
Phone:	Home:	Work:	Cell:

SECTION C: SCREENING FOR VACCINE ELIGIBILITY

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

❑ **Dose I** Date received: month_____ day_____ year_____ Form (please circle): nasal spray shot

❑ **Dose 2** Date received: month_____ day_____ year_____ Form (please circle): nasal spray shot

SECTION D: STUDENT HEALTH HISTORY

The following questions will help us know if your child can get the 2009 H1N1 influenza vaccine. Please mark either **Yes** or **No** for each question. Do not leave any question unanswered.

If you answer "NO" to all of the following questions, your child can probably get the influenza vaccine. If you answer "YES" to one or more of the following questions, your child may be able to get the H1N1 vaccine, but we will contact you to discuss your options.

	Yes	No
1. Has your child ever had a serious allergic reaction to eggs or the antibiotic gentamicin?	❑	❑
2. Has your child ever had a serious reaction to a previous dose of seasonal flu vaccine?	❑	❑
3. Has your child ever had Guillain-Barré syndrome (GBS), (i.e. paralysis) within 6 weeks after receiving a flu vaccine?	❑	❑
4. Is your child taking any prescription medication to prevent or treat flu?	❑	❑
5. Does your child have any other serious allergies that you know of? Please list:_____ _____	❑	❑
If answer Yes to any question (1-5) ⇨ Medical Screening		
6. Does your child have asthma, wheezing, difficulty breathing, or lung disease?	❑	❑
7. Does your child have a long-term health problem such as heart disease, kidney disease, metabolic disease (e.g., **diabetes**), or blood disorders (e.g., **anemia**)?	❑	❑
8. Does your child have a weakened immune system caused by cancer, cancer treatment (e.g., x-rays or drugs), HIV/AIDS, other disorders, or medicine (e.g. steroids)?	❑	❑
9. Does your child live with or have a close contact with anyone with a severely weakened immune system requiring care in a protected environment (such as a hospitalized family member receiving chemotherapy)?	❑	❑
10. Is your child receiving aspirin or other aspirin-containing therapy?	❑	❑
11. Has your child received a MMR (measles/mumps/rubella), varicella (chickenpox), or the live intranasal seasonal influenza vaccine (LAIV) within the past 4 weeks?	❑	❑
12. Does your child have a muscle or nerve disorder (such as cerebral palsy) that can lead to breathing or swallowing problems?	❑	❑
13. Is your child pregnant or nursing?	❑	❑
14. Is your child under the age of 2?	❑	❑
If answer Yes to any question (6-14) ⇨ NO LAIV		

SECTION E: CONSENT FOR CHILD'S VACCINATION

I have read the **2009 H1N1 Influenza CDC Vaccination Information Statements (VIS)** for the H1N1 influenza shot and for the nasal spray. I understand the risks and benefits, and give consent to the Health Department and its authorized staff for my child (named at the top of this form) to get vaccinated with this vaccine.

I understand that if my child is under 10 years of age, two doses of the H1N1 influenza vaccine are required. Each dose will be administered approximately one month apart. I give consent for my child to receive two doses of the H1N1 vaccine, each dose spaced about 3 – 4 weeks apart.

Signature of Parent or Legal Guardian: _____ **Date:** _____ / _____ /_____

SECTION F: OFFICE OF PRIVACY AND SECURITY
Authorization for Disclosure of Protected Health Information

As the person signing this authorization, I understand that I am giving permission to the Virginia Department of Health (VDH) to disclose personal health information to the person(s) or organization(s) indicated below.

- I understand the provision of treatment to my child cannot be conditioned on my signing of this Authorization for Disclosure Section.
- Any health information re-disclosed by you will no longer be protected by this authorization.
- The original or a copy of the authorization shall be included in my child's medical record.
- I have the right to revoke this authorization at any time, except to the extent that action has been taken prior to my request to withhold my child's medical record. The request must be in writing and will be effective upon delivery to the provider in possession of my child's medical records.
- I authorize VDH to disclose my child's health information to the child's primary care physician and school.
- I understand that this record will be retained for ten years after the last visit or for five years after age 18, whichever comes later.
- I understand this document will be given to and retained by the public health department and will not be maintained by the school.

SECTION G: NOTICE OF DEEMED CONSENT
(Required by §32.1-45.1 of the Code of Virginia (1950), as amended)

If the health care provider or the person acting under the health care provider's direction and control is directly exposed to my child's blood in a way that may transmit disease, I understand that the law requires my child to give a venous blood sample for further tests. I understand that the tests to be performed are for human immunodeficiency virus (HIV), hepatitis and/or other infectious diseases and that a physician or health care provider will inform me and the exposed provider of the results of the test.

I understand that the Virginia Department of Health will not release private medical records unless authorized above or to continue care.

_____	_____	_____
Please Print Your Name (parent or legal guardian)	Signature	Date

HEALTH DEPARTMENT USE ONLY

Date Dose Administered	Vaccine Manufacturer	Item code	Dose	Dose Number (1st or 2nd)	Lot Number	Vaccine Administration Site	Provider #
	MedImmune	Nasal Spray	0.2 ml			NAS	
	Sanofi	Prefilled Syringe 6 mos. through 35 mos.	0.25 ml			RA LA RL LL	
	Sanofi	Prefilled Syringe ≥ 36 mos.	0.5 ml			RA LA	
	Sanofi	Multi Dose Vial ≥ 6 mos.	(circle one) 0.25 ml 0.5 ml			RA LA RL LL	
	Novartis	Prefilled Syringe ≥ 4 yrs.	0.5 ml			RA LA	
	Novartis	Multi Dose Vial ≥ 4 yrs.	0.5 ml			RA LA	
	CSL	Prefilled Syringe ≥ 3 yrs.	0.5 ml			RA LA	
	CSL	Multi Dose Vial ≥ 3 yrs.	0.5 ml			RA LA	

Comments: (enter reason if vaccine not administered)

Provider Signature:_____ Date:_____/ _____/ _____