Official Use Only: Priority Status

- ☐ Pregnant women
- ☐ Household contacts of children under 6 months
- ☐ Person 6 months to 24 years old
- ☐ Adults, 25 years of age or older with serious chronic illness
- ☐ Healthcare workers and EMS personnel

2009 H1N1 Vaccine Parental Consent Form

Name of child: ______________________________

Last First Middle

Date of Birth: ____/____/____

Gender: Male Female

Language: English Spanish Other: ____________

Address: ______________________________

Street City, State, Zip Code

Home Phone: ____________ **Emergency Phone**: ____________

Birth State/Country: ____________ **Primary Doctor**: ____________

Consent Statement

I have been given the 2009-2010 CDC Vaccine Information Statement (VIS) for the 2009 H1N1 vaccine, read this document, and have no further questions at this time. I understand the risks and benefits of receiving the vaccine in either form and acknowledge that no guarantees have been made concerning the vaccine's success. I understand the side effects and warnings of the vaccines. In addition, I am aware that my child may require two doses if he/she is 9 years of age or younger.

*I give permission for my child to receive: (**please check one box only**)*

H1N1 Injection H1N1 Mist (nasal vaccine), if available Either vaccination type depending on availability

If 18 years of age or older

Signature of Participant: ______________________ **Date**: ____________

If child is under the age of 18 AND you as a parent or legal guardian are consenting to the vaccination of your child, you must complete this form and sign below.

Signature of Parent / Legal Guardian: ______________________ **Date**: ____________

PRINTED Name of Parent / Legal Guardian: ______________________

Check One: Mother Father Legal Guardian

Address: ______________________
(if different from child)

Street State, Zip Code

Day Phone: ( ) -

Please complete both sides of this form. ALL information is required for PA Dept of Health Statewide Immunization Information System (SIIS) registry

Please answer the following questions: (Circle either Yes or No)

1	Does your child have asthma, recurrent wheezing or active wheezing?	Yes	No
2	Has your child received a H1N1 vaccination?	Yes	No
3	Has your child ever had a life threatening reaction to ANY vaccination?	Yes	No
4	Does your child have any allergies to items such as eggs, egg proteins, gentamicin, gelatin or arginine, or have a special medical condition?	Yes	No
	If Yes, please explain: ______________________________		
5	Has your child received any vaccinations within the past 30 days?	Yes	No
	If Yes, please provide vaccination name and date: ______________________________		
6	Has your child ever had Guillain-Barre syndrome?	Yes	No
7	Does your child have any disease or take any medications that lower the body's immune system or have close contact with anyone who has a weakened immune system?	Yes	No
	If Yes, please explain: ______________________________		
8	Does your child have any of the following health problems?	Yes	No
	Heart Disease · Kidney Disease · Diabetes · Receiving aspirin or aspirin containing therapy		
	Other: ______________________________		
9	Is your child pregnant or nursing?	Yes	No

Race: White Black Asian Other: ____________________

Hispanic: Non-Hispanic
Cuban Mexican Puerto Rican
Central American Dominican South American
Other: ______________________________

Health Plan: (this information is for statistical purposes only and will not be used to bill any organization)
Private Insurance No Insurance CHIP Medical Assistance-ACCESS-Medicaid
Medicare Other:

Official Use: Provider Name: _________ Provider Initial: _________ Date: _________
Route: Intranasal Intramuscular- RD LD Lot #____________ Exp. Date: __________
Other Info: Child refused Parent/Guardian notified of vaccination

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