



Charlie Crist
Governor

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State Surgeon General

2009 H1N1 Influenza Intranasal Vaccine Consent Form

Name of child receiving vaccination: _____ Birth Date: _____

Gender: M F Race: White Black Hispanic Asian

American Indian or Alaskan Native Multi-Racial Not Known

School: _____ Teacher's Name: _____ Grade: _____

Home Address: _____ Zip Code: _____

Home Phone: _____ Emergency Contact Number: _____

Is your child covered by Medicaid? YES NO Medicaid Number: _____

Please circle YES or NO to the questions below: (If you answer YES to one or more of questions 1-10, your child will not be given the H1N1 vaccine at school. Please contact your private physician with any questions.)

- 1. Is your child allergic to eggs, egg protein, Gentamycin, gelatin, or arginine? YES NO
- 2. Has your child had a life-threatening reaction to a previous flu vaccination? YES NO
- 3. Does your child have a muscle or nerve disorder such as Guillain-Barre syndrome or cerebral palsy? YES NO
- 4. Is your child currently receiving aspirin or aspirin containing therapy? YES NO
- 5. Does your child have asthma? YES NO
- 6. Is your child under 5 years old and he/she has had one or more episodes of wheezing during the past year? YES NO
- 7. Does your child have any diseases (such as cancer, lupus, HIV/AIDS) or take a medication (such as steroids or chemotherapy) that lowers the body's resistance to infection? YES NO
- 8. Does your child have any of the following long-term health problems? YES NO
If you answered YES, please circle which one(s)

Heart disease Lung disease Kidney or Liver disease

Metabolic disease (Diabetes) Anemia or other blood disorder

- 9. Is your child pregnant? YES NO
- 10. Has your child received the "seasonal flu mist" or any other live vaccine in the past 28 days? YES NO

If your child is under 10 years of age, a second dose is recommended to be given in one month. At that time, the nurse will return to the school to administer the second dose.

- 10. Is your child under 10 years of age? YES NO
- 11. Has your child had a **2009 H1N1 flu vaccine** before? YES NO
Date of prior H1N1 flu vaccination: _____

If you wish for your child to receive the 2009 H1N1 Influenza vaccine, please sign your consent on back of this form.

