New York State Department of Health
Bureau of Immunization

2009 H1N1 Influenza Immunization Screening and Consent Form For Minors

Name (please print)	Date of Birth	Age	Date of Immunization (to be completed by vaccinator)
Address	City	State	Zip
Parent/Guardian (please print)	Sex F M	Patient Phone	
Physician's Name	Physician's Address		
School/Office Site Where Vaccine is Administered	Mother's Maiden Name(required)		

PLEASE ANSWER THESE QUESTIONS FOR YOUR CHILD

Indications	Has your child received a nasal flu vaccine within the last 28 days? If yes, please specify______________________	☐ Yes	☐ No
	Is your child between 6 months and 24 years of age?	☐ Yes	☐ No
	Does your child work in healthcare or emergency medical services?	☐ Yes	☐ No
	Does your child have a chronic medical condition or weakened immune system?	☐ Yes	☐ No
	Is your child pregnant?	☐ Yes	☐ No
	Is there a child under 6 months of age in your home?	☐ Yes	☐ No
Contraindications	Is your child sick with fever today?	☐ Yes	☐ No
	Has your child ever had a serious reaction to the nasal spray or flu shot vaccine?	☐ Yes	☐ No
	Has your child ever had a severe allergy to eggs, a severe allergy to a component of the seasonal flu vaccine, or an allergic reaction to latex?	☐ Yes	☐ No
	Has your child ever had Guillain Barre' Syndrome?	☐ Yes	☐ No
LAIV Contraindications	Does your child have close contact with anyone with a severely weakened immune system or are you pregnant?	☐ Yes	☐ No
	Does your child have asthma or has your child had wheezing episodes in the last year?	☐ Yes	☐ No
	Is this child or teen to be vaccinated receiving long term aspirin treatment?	☐ Yes	☐ No
	Has your child recently taken or is he/she presently taking antiviral medications?	☐ Yes	☐ No

Influenza Consent

I have read, or had explained to me, the Vaccine Information Sheet (VIS) about 2009 H1N1 influenza vaccination. I have had a chance to ask questions which were answered to my satisfaction, and I understand the benefits and risks of the vaccination as described. I request that the 2009 H1N1 influenza vaccination be given to my child (for whom I am authorized to make this request).

____ ______________________

Signature of parent or guardian Date

Area Below to be Completed by Vaccinator

Administration Site ☐ Left Deltoid ☐ Right Deltoid ☐ Left Thigh ☐ Right Thigh ☐ Nasal

Dosage ☐ 0.5 ml ☐ 0.25ml ☐ LAIV

VIS Date _____________ Manufacturer & Lot Number ____

☐ I have reviewed side effects with patient (parent or guardian)

Vaccinator Signature ____

Next Immunization Date: ☐ Next Year ☐ In 4 weeks ☐ Other