



If this document is incomplete in any section the vaccine will not be administered. No telephone or proxy request for the vaccine will be accepted

SCHOOL FORM

School Site \_\_\_\_\_

H1N1 Influenza Vaccine ADMINISTRATION RECORD

STUDENT'S NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

AGE: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ CONTACT PHONE NUMBER \_\_\_\_\_
STREET CITY COUNTY STATE ZIP
MONTH DAY YEAR

RACE: (Check ONE or MORE) (W) White (B) Black or African American (N) American Indian or Alaska Native
(A) Asian (H) Native Hawaiian or Other Pacific Islander ETHNICITY: Hispanic or Latino (Y) Yes or (N) No

SEX: (Check ONE) Male Female

Y N

- Has your child had a previous H1N1 vaccine? Nasal Shot DATE:
Does your child have a serious allergy to eggs?
Does your child have any other serious allergies? Please list
Has your child ever had a serious reaction to a previous dose of flu vaccine?
Has your child ever had Guillain-Barre Syndrome (a temporary severe muscle weakness) within 6 weeks after receiving a flu shot?
Has your child been vaccinated within the past 30 days? Vaccine Date
Has your child had a flu vaccination within the past 30 days? Inactivated Influenza (shot) Intranasal Vaccine (nasal mist)
Does your child have any of the following: asthma, diabetes, disease of the lungs, heart, kidneys, liver, nerves, or blood?
Is your child on long-term aspirin or aspirin containing therapy (does your child take aspirin every day)?
Does your child have a weak immune system (HIV, cancer, or medications such as steroids or those used to treat cancer)?
Is your child pregnant?
Does your child have close contact with a person who is immune compromised? (example: someone who has recently had a bone marrow transplant)?

If you answered "yes" to any of the above questions your child may not be able to receive the H1N1 vaccine at school.

Louisville Metro Department Public Health Wellness may keep this record in a medical file. They will record what vaccine was given, when the vaccine was given, the name of the company that made the vaccine, the vaccine's special lot number, the vaccine injection site, the signature and title of the person who gave the vaccine, and the address where the vaccine was given.

I have read or have had explained to me the 2009-2010 Vaccine Information Statements (VIS) and understand the risks and benefits for each vaccine and consent for my child to have : (Check one)

- ( ) Either the Live, Intranasal H1N1 influenza vaccine or the Inactivated H1N1 influenza vaccine as explained in the 2009-2010 Inactivated H1N1 influenza vaccine, (VIS dated 10/2/09) and the Live, Intranasal H1N1 influenza vaccine, (VIS dated 10/2/09)
( ) The Inactivated H1N1 influenza vaccine (shot) as explained in the 2009-2010 Inactivated H1N1 influenza vaccine, (VIS dated 10/2/09)
( ) The Live, Intranasal H1N1 influenza vaccine (nasal mist) as explained in the 2009-2010 Live, Intranasal H1N1 influenza vaccine, (VIS dated 10/2/09)

X \_\_\_\_\_ DATE: \_\_\_\_\_

Signature of person to receive vaccine or person authorized to make the request (parent or legal guardian)

I acknowledge (with my initials) that a HIPAA Privacy Notice was provided to me. \_\_\_\_\_

I DO NOT GIVE CONSENT to Louisville Metro Department of Public Health and Wellness and Jefferson County Public Schools for my child named at the top of this form to be vaccinated with this vaccine.

Are you getting the vaccine elsewhere for your child? Yes No

\_\_\_\_\_, DATE: \_\_\_\_\_

Signature of parent or legal guardian

FOR Louisville Metro Department of Public Health and Wellness USE ONLY

Vaccine Manufacturer: \_\_\_\_\_ Vaccine Lot Number: \_\_\_\_\_

Injection Site: \_\_\_\_\_

Signature and Title of Provider: \_\_\_\_\_ Provider#: \_\_\_\_\_

NOTES: \_\_\_\_\_