

Section 1: Information about Child to Receive Vaccine (please print)

STUDENT'S NAME (Last)	(First)	(M.I.)	STUDENT'S DATE OF BIRTH (MM/DD/YYYY)	
PARENT/LEGAL GUARDIAN'S NAME (Last)	(First)	(M.I.)	STUDENT'S AGE	STUDENT'S GENDER M/F
ADDRESS			PARENT/GUARDIAN DAYTIME PHONE NUMBER	
CITY	STATE	ZIP		
SCHOOL NAME			GRADE	

Section 2: Screening for Vaccine Eligibility

The following questions will help us know if your child can get the 2009 H1N1 influenza vaccine. Please mark YES or NO for each question.

If you answer "No" to all four of the following questions, your child can probably get the influenza vaccine. If you answer "Yes" to one or more of the following four questions, your child may be able to get the 2009 H1N1 vaccine, but we will contact you to discuss your options.

	YES	NO
1. Does your child have a serious allergy to eggs?		
2. Does your child have any other serious allergies that you know of? If yes, please list:		
3. Has your child ever had a serious reaction to a previous dose of flu vaccine?		
4. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?		

Section 3: Consent

I have read or had explained to me the 2009-2010 Vaccine Information Statement for the 2009 H1N1 influenza vaccine and understand the risks and benefits.
I GIVE CONSENT to the Ohio Department of Health and the Medina County Health Department staff for my child named at the top of this form to get vaccinated with this vaccine. (If this consent form is not signed, dated, and returned, your child will not be vaccinated at school.)
Signature of Parent/Legal Guardian: _____
Date (MM/DD/YYYY): _____

Section 4: Vaccination Record (FOR ADMINISTRATIVE USE ONLY)

Vaccine	Date Dose Administered	Injection Site (circle)	Dose Number	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine and Administrator	Recommend second Dose? Y/N
2009 H1N1		Left Deltoid IM					
		Left Anterolateral Thigh					
2009 H1N1 Dose 2		Left Deltoid IM					
		Left Anterolateral Thigh					



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