

**CITY OF PEABODY
DEPARTMENT OF HUMAN SERVICES**

24 Lowell Street
Peabody, Massachusetts 01960
(978) 538-5926
Fax: (978) 538-5990

BOARD OF HEALTH
JOHN J. BARRY III, CHAIRMAN
STEPHEN S. KALIVAS, R.Ph.
EUGENE F. SMITH, M.D.

SHARON CAMERON
DIRECTOR

**H1N1 Influenza Injectable Vaccination
Child Vaccine Administration Record**

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

CHILD'S NAME (Last)		(First)	(M.I.)	CHILD'S DATE OF BIRTH / /	
PARENT/LEGAL GUARDIAN'S NAME (Last)		(First)	(M.I.)	CHILD'S AGE	CHILD'S GENDER M / F
ADDRESS			PARENT/GUARDIAN DAYTIME PHONE NUMBER:		
CITY	STATE	ZIP			
SCHOOL NAME			GRADE/CLASS		
Medical Insurance Information (Insurance Company and Group/Policy Number):					

Section 2: Screening for Vaccine Eligibility

If your child has already been vaccinated with 2009 H1N1 flu vaccine, please tell us the number of doses and dates of vaccination. Dose 1 Date received: month ___ day ___ year ___ Form (please circle): nasal spray shot
 Dose 2 Date received: month ___ day ___ year ___ Form (please circle): nasal spray shot

The following questions will help us know if your child can get the 2009 H1N1 flu vaccine. Please mark YES or NO for each question. If you answer "YES" to one or more of the four questions, your child will not be able to receive the 2009 H1N1 flu vaccine unless there is a note from your child's health care provider approving the vaccination. If you answer "NO" to the following questions your child will receive the vaccine unless a concern arises following additional screening. If you are not sure of the answers to these questions, please check with your child's healthcare provider.

	YES	NO
1. Does your child have a serious allergy to eggs?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your child have a serious allergy to gentamicin, neomycin, polymixin or gelatin?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has your child ever had a serious reaction to a previous dose of flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>

List other serious allergies: _____

Section 3: Consent

CONSENT FOR CHILD'S VACCINATION:

I have been given a copy and have read or had explained to me the 2009-2010 Vaccine Information Statement for the H1N1 flu vaccine and understand the risks and benefits.

I VOLUNTARILY GIVE CONSENT for my child named at the top of this form to get vaccinated with this vaccine. Children younger than 10 years of age need 2 doses of vaccine. (If this consent is not signed, dated and returned, then your child will not be vaccinated.)

Signature of Parent/Legal Guardian

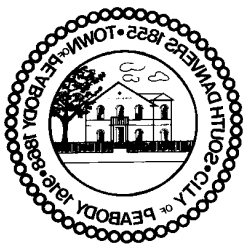
Date: month ___ day ___ year ___

I DO NOT GIVE CONSENT for my child named at the top of this form to get vaccinated with this vaccine.

Signature of Parent/Legal Guardian

Date: month ___ day ___ year ___

PLEASE BE SURE TO READ AND SIGN THE REVERSE SIDE OF THIS FORM



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Section 4: Permission to Share Information:

I, _____, give permission to the individual and/or entity that administered the 2009
(Print your name)

H1N1 vaccine to my child _____ to share copies of the 2009 H1N1 consent
(Print child's full name)

form and vaccination record with my child's school and health care provider named below, as well as with the
Massachusetts Department of Public Health and the local board of health in my community. I also give permission
for each of these entities to share the 2009 H1N1 consent form and vaccination record with each other.

My child's health care provider:
Name: _____

My child's school:
Name: _____

Address: _____

Address: _____
(at a minimum include Town)

- This health information is disclosed at my request and to ensure my child is appropriately vaccinated.
- This permission expires at the end of the 2009-2010 school year.
- If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information received may no longer be protected by federal privacy regulations. State privacy regulations cover information received by the MA Department of Public Health and local boards of health.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my child's ability to obtain the vaccination.
- I understand that I may inspect or copy the protected health information to be disclosed under this permission to share.
- Finally, I understand that I may withdraw this permission in writing at any time by sending written notification to:

City of Peabody Health Department, 24 Lowell Street, Peabody, MA 01960

(School/institution/individuals handling withdrawals MUST insert name and address)

However, if I withdraw permission at a later date, any vaccine consent form and vaccine record already shared will not be covered by the withdrawal.

Printed name of Parent or Guardian

Signature of Parent or Guardian

Address

Date

For Clinic/Office Use:

Vaccine name: _____ Date vaccine administered: _____

Injection site: _____ Date VIS given: _____ Date on VIS: _____

Vaccine manufacturer: _____ Vaccine lot number: _____

Name and title of vaccine administrator: _____

Clinic/office address: _____