LASALLE COUNTY HEALTH DEPARTMENT (LCHD)
H1N1 Swine Influenza Administration Record/Child Consent Form

School Name: _____ Grade: _____

PARENT PLEASE PRINT

Child's Name: _____Birthdate:_____/_____/_____ Age: _____
Last First MI

Parent's Name: _____ Day time phone/cell/work number: _____
(Parent we may need to contact you during clinic hours)

Address: _____City:_____Zip Code: _____

Physician Name: _____

1. Does your child have asthma, diabetes, heart disease or other chronic illness? _____ YES NO
2. Does your child have a serious allergy to eggs or latex? _____ YES NO
3. Has your child ever had any severe reactions to past flu vaccine? YES NO
4. Does your child have a history of Guillian-Barre Syndrome (a type of temporary severe muscle weakness) YES NO
5. Does your child they take a daily aspirin? YES NO
6. Has your child received a 2009 seasonal Flu vaccine? If yes, identify the type of vaccine they received: YES NO
   ☐ Nasal Spray ☐ Shot Date received Dose 1_____ Dose 2 _____
7. Has your child received a H1N1 Swine Flu vaccine: If yes, identify the type of vaccine did they received: YES NO
   ☐ Nasal Spray ☐ Shot Date received Dose 1_____ Dose 2_____
8. Female only: Is your child pregnant? YES NO

I am aware that an H1N1 Vaccine Information Statement is available to me at the LaSalle County Health Department web site, my children's school or LaSalle County Health Department. I have been provided the opportunity to have my questions answered to my satisfaction. I believe I understand the risks and benefits of H1N1 Influenza vaccine.

I GIVE CONSENT to the **LCHD** and its staff to vaccinate my child named at the top of this form with H1N1 Vaccine.

Signature of parent/guardian_____ Date:_____

I DO NOT GIVE CONSENT to the **LCHD** and its staff to vaccinate my child named at the top of this form with H1N1.

Signature of parent/guardian_____ Date: _____

FOR CLINIC USE ONLY

SITE OF INJECTION: ARM ☐ RIGHT ☐ LEFT LEG ☐ RIGHT ☐ LEFT

_____1ST DOSE _____2ND DOSE _____O.5 ml Dose _____0.25 ml Dose

_____Intranasal 0.2 ml Dose _____1st Dose _____2nd Dose

Nurse's Signature:_____