

H1N1 (SWINE FLU) VACCINE

(ALL STUDENTS MUST RETURN FORM WITH A YES OR NO ANSWER)

The Harrison County Health Department will be giving the H1N1 (Swine) Flu Vaccine (in shot form only) to students at Lanesville Community Schools in the near future. The **optional** vaccine will be given FREE. The vaccine will be given during the school day. Watch the newsletters and school website for dates.

- Age 9 years and younger will need 2 shots, 3-4 weeks apart (both given at school)
- Ages 10 and up will need only 1 shot

The H1N1 permission form(on back of this letter) must be completely filled out and signed by the parent or guardian in order for the vaccine to be given at school. **All students need to return the form. Sections 1, 3 and 4 must be completed even if you do not want your child to receive the vaccine. The form must be returned to the school office by October 29, 2009.**

If you have questions regarding the vaccine, please contact the Harrison County Health Department at 738-3237 or visit www.flu.gov

*****We are in need of volunteers to act as "huggers" for students when they receive the vaccine. All volunteers must have an approved criminal background check on file with the school. Call Carol Cox at 952-3000 ext 205 to volunteer.*****

2009 H1N1 Influenza Vaccine Consent Form

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

STUDENT'S NAME (Last)		(First)	(M.I.)	STUDENT'S DATE OF BIRTH month _____ day _____ year _____	
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

If your child has already been vaccinated with 2009 H1N1 influenza vaccine, please tell us the number of doses and dates of vaccination.

- | | | | | |
|---------------------------------|--|-----------------------|-------------|------|
| <input type="checkbox"/> Dose 1 | Date received: month ____ day ____ year ____ | Form (please circle): | nasal spray | shot |
| <input type="checkbox"/> Dose 2 | Date received: month ____ day ____ year ____ | Form (please circle): | nasal spray | shot |

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

A. 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?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your child have any other serious allergies? Please list: _____	<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"/>

Section 3: Consent

CONSENT FOR CHILD'S VACCINATION: I understand children under 10 years of age will require 2 shots, separated by 3-4 weeks. 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 STATE/LOCAL health department and its staff for my child named at the top of this form to be vaccinated with this vaccine. (If this consent form is not signed, dated, and returned, then your child will not be vaccinated at school)

Signature of Parent/Legal Guardian _____

I **DO NOT GIVE CONSENT** to the STATE/LOCAL health department and its staff for my child named at the top of this form to be vaccinated with this vaccine.

Signature of Parent/Legal Guardian _____

Section 4: Permission to Release Information

By initialing this box, I am hereby indicating permission for my child's complete immunization record to be entered into CHIRP (Children's and Hoosiers' Immunization Registry Program). This will allow health care providers, hospitals, health departments, and schools access to my child's immunization record by a state monitored database.

_____ I do give my permission _____ I do not give my permission

Section 5: Vaccination Record

Vaccine	Date Dose Administered	Route	Dose Number (1st or 2nd)	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator
2009 H1N1	/ /	<input type="checkbox"/> IM				
2009 H1N1	/ /	<input type="checkbox"/> IM				