D H E C
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PARENTAL CONSENT FOR H1N1 VACCINATION

School Name:

Child's Last Name | Child's First Name | ☐ Male ☐ Female

Address | Child's Birth Date Month / Day / Year | Age | Race

City | State | Zip | Child's Grade | Child's Teacher

Parent/Guardian's Last Name | Parent/Guardian's First Name | Parent/Guardian Daytime Phone Number

Instructions: Please read the 2009-2010 Vaccine Information Statement for the H1N1 Influenza Vaccine that has been provided with this form and complete the gray areas below. If you have any questions, please call your child's primary healthcare provider or the DHEC Immunization/Flu Hotline at 1-800-27-SHOTS (1-800-277-4687).

Has your child received a 2009 H1N1 (swine) influenza vaccine (shot or nasal mist)? ☐ No ☐ Yes
If yes, when? Month/Day: _____

CONSENT FOR CHILD'S VACCINATION

Complete this section if you WANT your child to receive the H1N1 shot.
I have read or had explained to me the 2009-2010 Vaccine Information Statement for the H1N1 influenza vaccine and understand the risks and benefits. I have been given the opportunity to ask questions about the vaccine.
I GIVE CONSENT for my child, named at the top of this form, to get the 2009 H1N1 influenza vaccination (shot) at the school clinic sponsored by the SC Department of Health and Environmental Control (DHEC). ***Note: If this consent form is not signed, dated and returned to the school, then your child will not be vaccinated at the school.***
Signature of Parent/Legal Guardian:

_____

Date: _____

Complete this section if you DO NOT WANT your child to receive the H1N1 shot.
I have read or had explained to me the 2009-2010 Vaccine Information Statement for the H1N1 influenza vaccine and understand the risks and benefits. I have been given the opportunity to ask questions about the vaccine.
I DO NOT GIVE CONSENT for my child, named at the top of this form, to get the 2009 H1N1 influenza vaccination (shot) at the school clinic sponsored by the SC Department of Health and Environmental Control (DHEC). ***Note: Please return the completed consent to the school declining vaccination.***

Signature of Parent/Legal Guardian:

_____

Date: _____

Please answer the following questions about your child ONLY if you have given consent for your child to receive the H1N1 vaccine (shot) at the school:

☐ No ☐ Yes	1. Has your child ever had a serious reaction to eggs **OR** a serious reaction to a previous flu vaccine (seasonal or H1N1) that caused any of the following: wheezing; trouble breathing; hives and itching all over the body; swelling in the mouth or throat; very low blood pressure or shock?
☐ No ☐ Yes	2. Has your child ever had Guillain-Barré Syndrome (a rare type of temporary severe muscle weakness)?
☐ No ☐ Yes	3. Does your child have any other serious (life threatening) allergies? If yes, to what:

IF YOU ANSWERED YES TO QUESTION NUMBER 1 OR 2, YOUR CHILD WILL NOT BE ABLE TO RECEIVE THE VACCINE AT SCHOOL. PLEASE CONTACT YOUR CHILD'S PRIMARY HEALTHCARE PROVIDER TO FIND OUT IF YOUR CHILD CAN RECEIVE THE VACCINE.

THE FOLLOWING SECTION WILL BE COMPLETED WHEN THE VACCINE IS GIVEN.

H1N1 Inactivated VACCINE	Dose #	Route:		MANUFACTURER:	LOT #:	VIS DATE 10/02/09
	☐ 1 ☐ 2	IM	☐ LA ☐ RA ☐ LL ☐ RL			

☐ Vaccination Card and "After Shot Care" given to Student ☐ Unable to vaccinate: _____

Nurse Signature_____ Date _____

LABEL