

MIDDLE/HIGH SCHOOL CONSENT/SCREENING FORM

Hillsborough County Health Department
1105 E. Kennedy Blvd., Tampa, FL 33602

The Purpose of this document is to authorize the Hillsborough County Health Department to administer the following vaccine to the named person at a Hillsborough County Public School

Fill in the Grey areas only (PLEASE PRINT)

Last Name: _____ First Name: _____ MI: _____
Date of Birth: _____ Age: _____ Race: _____ Grade: _____ Male Female
Address (Street): _____ City: _____ State: _____ Zip Code: _____
Phone #: _____

Do not return this consent form if you do not wish your child/minor to receive the H1N1 (swine flu) vaccine.

My preference for my child's H1N1 (Swine Flu) vaccine is the following:

- Inactivated injectable influenza vaccine ONLY
 Live intranasal influenza vaccine ONLY
 Either injectable influenza vaccine OR live intranasal influenza vaccine

Please answer the following questions:

Are you a minor? (<i>Parent or guardian must sign below if under 18 years of age</i>)	YES	NO		
Is your child allergic to eggs, egg products, Gentamicin, gelatin, arginine, or Thimeresol?	YES	NO	Is your child pregnant?	YES NO
			Is your child receiving aspirin therapy?	YES NO
Has your child ever had a severe reaction to influenza vaccines?	YES	NO	Does your child have asthma, recurrent or active wheezing?	YES NO
Has your child ever had any neurological disorders such as: Guillain-Barré Syndrome, MS cerebral palsy or seizures?	YES	NO	Does your child have any disease such as: diabetes, heart disease, cancer, lupus, HIV/AIDS or blood disorders?	YES NO
Does your child have a cold, fever, or other active illness?	YES	NO	Is your child taking medications that may lower their body's resistance to infection e.g. steroids or chemotherapy?	YES NO

Has your child received a vaccine within the past 30 days? YES NO What type _____

I have read the Vaccine Information Statement about Novel H1N1 vaccine. My questions and concerns regarding Novel H1N1 have been addressed to my satisfaction by the Hillsborough County Health Department. I understand the benefits and risks of the H1N1 vaccine. I request the vaccine be given to the patient named above for which I am authorized to make this request. I have the legal authority, based on my relationship to the person indicated above to consent to administration of Novel H1N1 vaccine.

X _____ DATE: _____
Signature of person to receive vaccine or person authorized to make request

X _____ DATE: _____
(please print name of consenting adult)

I give consent for _____ to be given the vaccines requested above.
(child/minor name)

PLEASE CONTACT THE HILLSBOROUGH COUNTY HEALTH DEPARTMENT, (813) 307-8000 IF YOU HAVE ANY QUESTIONS

Influenza Vaccine MFG: _____ Lot #: _____ Exp date: _____ Inj site: _____ Route: _____

Title: _____
Date: _____ Signature of representative who administered vaccine