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? ***(Parent or guardian must sign below if under 18 years of age)*** YES NO

Is your child allergic to eggs, egg products, Gentamicin, gelatin, arginine, or Thimeresol? YES NO

Has your child ever had a severe reaction to influenza vaccines? 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 a cold, fever, or other active illness? YES NO

Is your child pregnant? YES NO

Is your child receiving aspirin therapy? YES NO

Does your child have asthma, recurrent or active wheezing? YES NO

Does your child have any disease such as: diabetes, heart disease, cancer, lupus, HIV/AIDS or blood disorders? 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**