



## Okaloosa County Health Department H1N1 Swine Flu Vaccination Consent Form



Family Information				
Street Address				Dot
City		State		Zip
Primary Contact Number			Alternate Contact Number	
Parent / Guardian Information			Child Information	
Last Name:		First Name:		I consent to the H1N1 Swine Flu vaccine administration for the child/children identified on this form. <span style="float: right;"><input type="checkbox"/> Y <input type="checkbox"/> N</span>
Date of Birth:		Age: <span style="margin-left: 20px;">Sex <input type="checkbox"/> M <input type="checkbox"/> F</span>		
I want the H1N1 Swine Flu vaccine for myself. <span style="float: right;"><input type="checkbox"/> Y <input type="checkbox"/> N</span>			Child # 1 Information	
<i>If you do not want the vaccine, skip to Child Information. ↗</i>			Last Name:	
			First Name:	
Are you pregnant? <i>(Females only)</i> <span style="float: right;"><input type="checkbox"/> Y <input type="checkbox"/> N</span>			Date of Birth:	
			Age: <span style="margin-left: 20px;">Sex <input type="checkbox"/> M <input type="checkbox"/> F</span>	
Do you have, or are you the caregiver for, children under the age of 6 months? <span style="float: right;"><input type="checkbox"/> Y <input type="checkbox"/> N</span>			I am the parent or legal guardian of this child. <span style="float: right;"><input type="checkbox"/> Y <input type="checkbox"/> N</span>	
Do you have any chronic diseases? <span style="float: right;"><input type="checkbox"/> Y <input type="checkbox"/> N</span>			Relationship:	
What? _____			This is this child's <input type="checkbox"/> 1st <input type="checkbox"/> 2nd H1N1 Swine Flu vaccine. <small>(Only children under age 10 need two doses of the vaccine)</small>	
Have you ever had a seasonal flu vaccine? <span style="float: right;"><input type="checkbox"/> Y <input type="checkbox"/> N</span>			Has this child ever had a seasonal flu vaccine? <span style="float: right;"><input type="checkbox"/> Y <input type="checkbox"/> N</span>	
Have you ever had a severe reaction to any vaccine? <span style="float: right;"><input type="checkbox"/> Y <input type="checkbox"/> N</span>			Has this child ever had a severe reaction to any vaccine? <span style="float: right;"><input type="checkbox"/> Y <input type="checkbox"/> N</span>	
Have you had any vaccines in the past 30 days? <span style="float: right;"><input type="checkbox"/> Y <input type="checkbox"/> N</span>			If this is this child's 2nd H1N1 Swine Flu vaccine, did he/she have a severe reaction to the 1st? <span style="float: right;"><input type="checkbox"/> Y <input type="checkbox"/> N</span>	
Have you taken Tamiflu or Relenza in the past 48 hours? <span style="float: right;"><input type="checkbox"/> Y <input type="checkbox"/> N</span>			Has this child had any vaccines, other than the H1N1 Swine Flu vaccine, in the past 30 days? <span style="float: right;"><input type="checkbox"/> Y <input type="checkbox"/> N</span>	
Have you had a fever of 100° or greater in the last 24 hours? <span style="float: right;"><input type="checkbox"/> Y <input type="checkbox"/> N</span>			Has this child taken Tamiflu or Relenza in the past 48 hours? <span style="float: right;"><input type="checkbox"/> Y <input type="checkbox"/> N</span>	
Have you ever taken a medication that caused swelling of the mouth or throat, difficulty breathing or shock? <span style="float: right;"><input type="checkbox"/> Y <input type="checkbox"/> N</span>			Has this child had a fever of 100° or greater in the last 24 hours? <span style="float: right;"><input type="checkbox"/> Y <input type="checkbox"/> N</span>	
Are you allergic to eggs? <span style="float: right;"><input type="checkbox"/> Y <input type="checkbox"/> N</span>			Has this child ever taken a medication that caused swelling of the mouth or throat, difficulty breathing or shock? <span style="float: right;"><input type="checkbox"/> Y <input type="checkbox"/> N</span>	
Do you have any questions or concerns about the H1N1 Swine Flu vaccine? <span style="float: right;"><input type="checkbox"/> Y <input type="checkbox"/> N</span>			Is this child allergic to eggs? <span style="float: right;"><input type="checkbox"/> Y <input type="checkbox"/> N</span>	
			Does this child have any chronic illnesses? <span style="float: right;"><input type="checkbox"/> Y <input type="checkbox"/> N</span>	

**Parent/Guardian:** I was given, read and understand the H1N1 Swine Flu Vaccination Information Statement. I consent to receive the H1N1 Swine Flu vaccine (if applicable). I understand the department's Notice of Privacy Practices is available at: [www.HealthyOkaloosa.com](http://www.HealthyOkaloosa.com). I have the legal authority, based on my relationship to the child/children on this form, to consent to the H1N1 Swine Flu vaccine administration for the identified child/children and do consent to the vaccine administration for each identified child. I also understand our vaccinations will be recorded in the Florida SHOTS Immunization Registry.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Do not write in this area. Staff Use Only.	Parent/ Guardian				Child #1				
	Vaccine Site		Formulation		Vaccine Site		Formulation		
	LDT = Left Deltoid RDT = Right Deltoid LLT = Left Lateral Thigh RLT = Right Lateral Thigh IN = Intra-nasal <hr/> LAIV = Live Attenuated Intra-nasal Vaccine PF = Preservative Free	LDT	Sanofi Pasteur	0.25 ml PF	LDT	Sanofi Pasteur	0.25 ml PF	RDT	Novartis
	RDT	Novartis	0.50 ml PF	LLT	CSL	0.25 ml	RLT	LAIV	0.50 ml
	LLT	CSL	0.25 ml	IN	IN	Lot #	IN	Lot #	IN
	RLT	LAIV	0.50 ml						
	IN	Lot #							
	Vaccinator Initials: _____				Vaccinator Initials: _____				

Child # 2 Information				Child # 3 Information			
Last Name:		First Name:		Last Name:		First Name:	
Date of Birth:		Age:	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth:		Age:	Sex <input type="checkbox"/> M <input type="checkbox"/> F
I am the parent or legal guardian of this child.			<input type="checkbox"/> Y <input type="checkbox"/> N	I am the parent or legal guardian of this child.			<input type="checkbox"/> Y <input type="checkbox"/> N
Relationship:				Relationship:			
This is this child's <input type="checkbox"/> 1st <input type="checkbox"/> 2nd H1N1 Swine Flu vaccine. (Only children under age 10 need two doses of the vaccine)				This is this child's <input type="checkbox"/> 1st <input type="checkbox"/> 2nd H1N1 Swine Flu vaccine. (Only children under age 10 need two doses of the vaccine)			
Has this child ever had a seasonal flu vaccine?			<input type="checkbox"/> Y <input type="checkbox"/> N	Has this child ever had a seasonal flu vaccine?			<input type="checkbox"/> Y <input type="checkbox"/> N
Has this child ever had a severe reaction to any vaccine?			<input type="checkbox"/> Y <input type="checkbox"/> N	Has this child ever had a severe reaction to any vaccine?			<input type="checkbox"/> Y <input type="checkbox"/> N
If this is this child's 2nd H1N1 Swine Flu vaccine, did he/she have a severe reaction to the 1st?			<input type="checkbox"/> Y <input type="checkbox"/> N	If this is this child's 2nd H1N1 Swine Flu vaccine, did he/she have a severe reaction to the 1st?			<input type="checkbox"/> Y <input type="checkbox"/> N
Has this child had any vaccines, other than the H1N1 Swine Flu vaccine, in the past 30 days?			<input type="checkbox"/> Y <input type="checkbox"/> N	Has this child had any vaccines, other than the H1N1 Swine Flu vaccine, in the past 30 days?			<input type="checkbox"/> Y <input type="checkbox"/> N
Has this child taken Tamiflu or Relenza in the past 48 hours?			<input type="checkbox"/> Y <input type="checkbox"/> N	Has this child taken Tamiflu or Relenza in the past 48 hours?			<input type="checkbox"/> Y <input type="checkbox"/> N
Has this child had a fever of 100° or greater in the last 24 hours?			<input type="checkbox"/> Y <input type="checkbox"/> N	Has this child had a fever of 100° or greater in the last 24 hours?			<input type="checkbox"/> Y <input type="checkbox"/> N
Has this child ever taken a medication that caused swelling of the mouth or throat, difficulty breathing or shock?			<input type="checkbox"/> Y <input type="checkbox"/> N	Has this child ever taken a medication that caused swelling of the mouth or throat, difficulty breathing or shock?			<input type="checkbox"/> Y <input type="checkbox"/> N
Is this child allergic to eggs?			<input type="checkbox"/> Y <input type="checkbox"/> N	Is this child allergic to eggs?			<input type="checkbox"/> Y <input type="checkbox"/> N
Does this child have any chronic illnesses?			<input type="checkbox"/> Y <input type="checkbox"/> N	Does this child have any chronic illnesses?			<input type="checkbox"/> Y <input type="checkbox"/> N
Child # 4 Information				Do not write in this area. Staff use only.			
Last Name:		First Name:		Child # 2			
Date of Birth:		Age:	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Vaccine Site	Formulation		Lot #
I am the parent or legal guardian of this child. <input type="checkbox"/> Y <input type="checkbox"/> N			Relationship:	LDT RDT	Sanofi Pasteur	0.25 ml PF	
				LLT RLT	Novartis	0.50 ml PF	
This is this child's <input type="checkbox"/> 1st <input type="checkbox"/> 2nd H1N1 Swine Flu vaccine. (Only children under age 10 need two doses of the vaccine)			Relationship:	IN	CSL	0.25 ml	
					LAIV	0.50 ml	
Vaccinator Initials:				Child # 3			
Has this child ever had a seasonal flu vaccine?			<input type="checkbox"/> Y <input type="checkbox"/> N	LDT RDT	Sanofi Pasteur	0.25 ml PF	
Has this child ever had a severe reaction to any vaccine?			<input type="checkbox"/> Y <input type="checkbox"/> N	LLT RLT	Novartis	0.50 ml PF	
If this is this child's 2nd H1N1 Swine Flu vaccine, did he/she have a severe reaction to the 1st?			<input type="checkbox"/> Y <input type="checkbox"/> N	IN	CSL	0.25 ml	
Has this child had any vaccines, other than the H1N1 Swine Flu vaccine, in the past 30 days?			<input type="checkbox"/> Y <input type="checkbox"/> N		LAIV	0.50 ml	
Vaccinator Initials:				Child # 4			
Has this child taken Tamiflu or Relenza in the past 48 hours?			<input type="checkbox"/> Y <input type="checkbox"/> N	LDT RDT	Sanofi Pasteur	0.25 ml PF	
Has this child had a fever of 100° or greater in the last 24 hours?			<input type="checkbox"/> Y <input type="checkbox"/> N	LLT RLT	Novartis	0.50 ml PF	
Has this child ever taken a medication that caused swelling of the mouth or throat, difficulty breathing or shock?			<input type="checkbox"/> Y <input type="checkbox"/> N	IN	CSL	0.25 ml	
Is this child allergic to eggs?			<input type="checkbox"/> Y <input type="checkbox"/> N		LAIV	0.50 ml	
Vaccinator Initials:				LDT = Left Deltoid RDT = Right Deltoid LLT = Left Lateral Thigh RLT = Right Lateral Thigh IN = Intra-nasal			
Does this child have any chronic illnesses?			<input type="checkbox"/> Y <input type="checkbox"/> N	LAIV = Live Attenuated Intra-nasal Vaccine PF = Preservative Free			