

## Directions for H1N1 Vaccine Screening Forms, Consent Forms and Permission to Share Information

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1. When vaccinating an adult:
  - Fill out an appropriate screening questionnaire for the vaccine being administered. You can also opt to screen the patient verbally without a form.
  - Ask the individual to read and sign the Permission to *Share for Adult Immunization*. If the individual refuses to sign the Permission to Share, you may still vaccinate.
  
2. When vaccinating a child with their parent(s) or legal representative present:
  - Fill out an appropriate screening questionnaire for the vaccine being administered. You can also opt to screen the patient verbally without a form.
  - Ask the parent or legal guardian to read and sign the *Permission to Share Information when Parent is Present with Child*. If the parent or legal representative refuses to sign the permission to share you may still vaccinate the child.
  
3. When vaccinating a child without a parent or legal representative present:
  - Child must have an *H1N1 Influenza Vaccine Consent Form* completed by his or her parent or legal representative.
  - If parent or legal representative signed the consent to vaccinate and did not sign the permission to share, you may still vaccinate. The consent to vaccinate is required to be completed prior to vaccination; the permission to share is not required

(**Note:** See reverse side for additional instructions in schools and other settings where a child may be getting vaccinated when a parent or legal representative is **not** present)

**Additional Directions for H1N1 Vaccine Consent Forms and Permission to Share Information in Settings where a Child Is Being Vaccinated and the Parent or Legal Representative Is Not Present**

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*There is no federal requirement to obtain a signature prior to vaccination. However, state law generally requires the consent of a parent or legal representative for the vaccination of minors, if the parent or legal representative is not present at the time of vaccination. When children under 18 years of age are to be vaccinated in the absence of a parent or legal representative, clinic organizers must:*

1. Use MDPH developed consent and screening forms available at [www.mass.gov/dph](http://www.mass.gov/dph).
2. Ensure that the appropriate consent form is available for the type of vaccine to be administered at the clinic site. For example:
  1. If the site only has injectable H1N1 influenza (inactivated) vaccine available for administration, use the consent form for injectable flu shot only.
  2. Use the “combination” consent form if both injectable and H1N1 nasal spray (live) vaccine are available.

**Note: the combination form contains additional screening questions pertaining to the nasal spray (live) vaccine.**
3. Send home to parents or legal representative:
  1. The appropriate consent form
  2. The Vaccine Information Statement (VIS), which must be part of the consent process. VISs are available at [www.immunize.org](http://www.immunize.org).
4. Signed consent to vaccinate is required to be completed prior to vaccination, but the permission to share is not required. If parents want their child’s record to be shared with their provider and/or health departments, then they need to be sure to also sign the ‘permission to share section’ on the back of the consent form
5. For children requiring a second dose of H1N1 influenza vaccine, send home to the parents or legal representative a VIS and the *Reminder and Withdrawal Permission Form*.
6. Establish procedures for responding to questions from parents or legal representative by telephone or mail.
7. All consent forms must be returned with the proper signature to the clinic organizer prior to the administration of any vaccine.

## MDPH 2009 H1N1 Influenza Vaccine Consent Form --Injectable (Flu Shot) or Nasal Spray Vaccines (For use when parent is not present with child)

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

STUDENT'S NAME (Last)		(First)	(M.I.)	STUDENT'S DATE OF BIRTH / /	
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		
INSURANCE PLAN NAME		INSURANCE PLAN ID #		INSURANCE PLAN GROUP #	

### 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.

- Dose 1      Date received: month \_\_\_\_ day \_\_\_\_ year \_\_\_\_      Form (please circle):    nasal spray                  shot  
 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 "YES" to one or more of the four questions, your child will not be able to receive the 2009 H1N1 influenza vaccine in school unless there is a note from your child's health care provider approving the vaccination. If you answer "NO" to the following questions your child will receive the vaccine unless a concern arises following additional screening. If you are not sure of the answers to these questions, please check with your child's healthcare provider.**

	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"/>

**B. There are two kinds of 2009 H1N1 influenza vaccine. Your answers to the following questions will help us know which of the two kinds of vaccine your child can get.**

	YES	NO
1. Has your child been vaccinated with any vaccine (not just flu) within the past 30 days? Vaccine: _____ Date given: month ____ day ____ year ____	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your child have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood?	<input type="checkbox"/>	<input type="checkbox"/>
3. Is your child on long-term aspirin or aspirin-containing therapy (for example, does your child take aspirin every day)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Does your child have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Is your child pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does your child have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?	<input type="checkbox"/>	<input type="checkbox"/>

### Section 3: Consent

#### CONSENT FOR CHILD'S VACCINATION:

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 GIVE CONSENT for my child named at the top of this form to get vaccinated with this vaccine. Children younger than 10 years of age need 2 doses of vaccine. (If this consent is not signed, dated and returned, then my child will not be vaccinated.)

Signature of Parent/Legal Guardian \_\_\_\_\_

Date: month \_\_\_\_ day \_\_\_\_ year \_\_\_\_

Before the second dose you will receive a reminder.

I DO NOT GIVE CONSENT for my child named at the top of this form to get vaccinated with this vaccine.

Signature of Parent/Legal Guardian \_\_\_\_\_

Date: month \_\_\_\_ day \_\_\_\_ year \_\_\_\_

**PLEASE BE SURE TO READ AND SIGN THE REVERSE SIDE OF THIS FORM**

**Section 4: Permission to Share Information:**

I, \_\_\_\_\_, give permission to the individual and/or entity that administered the 2009  
 (Print your name)  
 H1N1 vaccine to my child \_\_\_\_\_ to share copies of the 2009 H1N1 consent form and  
 (Print child's full name)  
 vaccination record with my child's school and health care provider named below, as well as with the Massachusetts Department of Public Health and the local board of health in my community. I also give permission for each of these entities to share the 2009 H1N1 consent form and vaccination record with each other.

My child's health care provider: My child's school:  
 Name: \_\_\_\_\_ Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ Address: \_\_\_\_\_  
 (at a minimum include Town)

- This health information is disclosed at my request and to ensure my child is appropriately vaccinated.
- This permission expires at the end of the 2009-2010 school year.
- If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information received may no longer be protected by federal privacy regulations. State privacy regulations cover information received by the MA Department of Public Health and local boards of health.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my child's ability to obtain the vaccination.
- I understand that I may inspect or copy the protected health information to be disclosed under this permission to share.
- Finally, I understand that I may withdraw this permission in writing at any time by sending written notification to:

**(School/institution/individuals handling withdrawals must insert name and address)**

However, if I withdraw permission at a later date, any vaccine consent form and vaccine record already shared will not be covered by the withdrawal.

\_\_\_\_\_  
 Printed name of Parent or Guardian Signature of Parent or Guardian  
 \_\_\_\_\_  
 Address Date

**OPTIONAL FOR DOCUMENTATION OF IMMUNIZATION  
 (OTHER ADMINISTRATION RECORDS CAN BE USED)**

**FOR ADMINISTRATIVE USE ONLY**

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Section 5: Vaccination Record**

Vaccine	Date Given	Dose	Route	Dose Number (1st or 2nd)	Site	Vaccine Manufacturer	Vaccine Lot Number	Vaccine Information Statement		Name and Title of Vaccine Administrator
								Date on VIS	Date Given	
2009 H1N1	/ /		IM•IN							
2009 H1N1	/ /		IM•IN							

VIS sent home for: \_\_\_\_\_ Dose 1 \_\_\_\_\_ Dose 2 (if needed)

MDPH

**2009 H1N1 Influenza Vaccine Consent Form – Injectable (Flu Shot) Only**  
**(For use when parent is not present with child)**

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

STUDENT'S NAME (Last)		(First)	(M.I.)	STUDENT'S DATE OF BIRTH / /	
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/CLASS		
INSURANCE PLAN NAME		INSURANCE PLAN ID #		INSURANCE PLAN GROUP #	

**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 know if your child can get the 2009 H1N1 influenza vaccine. Please mark YES or NO for each question.**

**If you answer “YES” to one or more of the four questions, your child will not be able to receive the 2009 H1N1 influenza vaccine in school unless there is a note from your child’s health care provider approving the vaccination. If you answer “NO” to the following questions your child will receive the vaccine unless a concern arises following additional screening. If you are not sure of the answers to these questions, please check with your child’s healthcare provider.**

	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 that you know of? 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**

<b>CONSENT FOR CHILD’S VACCINATION:</b>	
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 GIVE CONSENT for my child named at the top of this form to get vaccinated with this vaccine. Children younger than 10 years of age need 2 doses of vaccine. (If this consent is not signed, dated and returned, then your child will not be vaccinated.) Signature of Parent/Legal Guardian _____ Date: month ___ day ___ year ____	I DO NOT GIVE CONSENT for my child named at the top of this form to get vaccinated with this vaccine. Signature of Parent/Legal Guardian _____ Date: month ___ day ___ year ____
Before the second dose you will receive a reminder.	

**PLEASE BE SURE TO READ AND SIGN THE REVERSE SIDE OF THIS FORM**

**Section 4: Permission to Share Information:**

I, \_\_\_\_\_, give permission to the individual and/or entity that administered the 2009  
 (Print your name)  
 H1N1 vaccine to my child \_\_\_\_\_ to share copies of the 2009 H1N1 consent form and  
 (Print child's full name)  
 vaccination record with my child's school and health care provider named below, as well as with the Massachusetts Department of Public Health and the local board of health in my community. I also give permission for each of these entities to share the 2009 H1N1 consent form and vaccination record with each other.

My child's health care provider: My child's school:  
 Name: \_\_\_\_\_ Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ Address: \_\_\_\_\_  
 (at a minimum include Town)

- This health information is disclosed at my request and to ensure my child is appropriately vaccinated.
- This permission expires at the end of the 2009-2010 school year.
- If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information received may no longer be protected by federal privacy regulations. State privacy regulations cover information received by the MA Department of Public Health and local boards of health.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my child's ability to obtain the vaccination.
- I understand that I may inspect or copy the protected health information to be disclosed under this permission to share.
- Finally, I understand that I may withdraw this permission in writing at any time by sending written notification to:

**(School/institution/individuals handling withdrawals must insert name and address)**

However, if I withdraw permission at a later date, any vaccine consent form and vaccine record already shared will not be covered by the withdrawal.

Printed name of Parent or Guardian \_\_\_\_\_ Signature of Parent or Guardian \_\_\_\_\_  
 Address \_\_\_\_\_ Date \_\_\_\_\_

**OPTIONAL FOR DOCUMENTATION OF IMMUNIZATION  
 (OTHER ADMINISTRATION RECORDS CAN BE USED)**

**FOR ADMINISTRATIVE USE ONLY**

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Section 5: Vaccination Record**

Vaccine	Date Given	Dose	Route	Dose Number (1st or 2nd)	Site	Vaccine Manufacturer	Vaccine Lot Number	Vaccine Information Statement		Name and Title of Vaccine Administrator
								Date on VIS	Date Given	
2009 H1N1	/ /		IM							
2009 H1N1	/ /		IM							

VIS sent home for: \_\_\_\_\_ Dose 1 \_\_\_\_\_ Dose 2 (if needed)

**PERMISSION TO SHARE VACCINE INFORMATION  
(FOR ADULT IMMUNIZATION)**

I, \_\_\_\_\_, give permission to the individual and/or entity that administered the 2009  
(Print your name)

H1N1 vaccine to me to share copies of the 2009 H1N1 vaccination record with my health care provider named below, as well as with the Massachusetts Department of Public Health and the local board of health in my community. I also give permission for each of these entities to share the 2009 H1N1 vaccination record with each other.

My health care provider:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

- This health information is disclosed at my request and to ensure that I am appropriately vaccinated.
- This permission expires one year from the signature date.
- If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information received may no longer be protected by federal privacy regulations. State privacy regulations cover information received by the MA Department of Public Health and local boards of health.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain the vaccination.
- I understand that I may inspect or copy the protected health information to be disclosed under this permission to share.
- Finally, I understand that I may withdraw this permission in writing at any time by sending written notification to:

\_\_\_\_\_  
**(School/institution/individuals handling withdrawals must insert name and address)**

However, if I withdraw permission at a later date, any vaccine record already shared will not be covered by the withdrawal.

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Address

\_\_\_\_\_  
Date

**PERMISSION TO SHARE VACCINE INFORMATION  
(FOR USE WHEN PARENT IS PRESENT WITH CHILD)**

I, \_\_\_\_\_, give permission to the individual and/or entity that administered the 2009  
(Print your name)

H1N1 vaccine to my child \_\_\_\_\_ to share copies of the 2009 H1N1 vaccination  
(Print child's full name)

record with my child's school and health care provider named below, as well as with the Massachusetts Department of Public Health and the local board of health in my community. I also give permission for each of these entities to share the 2009 H1N1 vaccination record with each other.

My child's health care provider:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

My child's school:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

(at a minimum include Town)

- This health information is disclosed at my request and to ensure my child is appropriately vaccinated.
- This permission expires at the end of the 2009-2010 school year.
- If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information received may no longer be protected by federal privacy regulations. State privacy regulations cover information received by the MA Department of Public Health and local boards of health.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my child's ability to obtain the vaccination.
- I understand that I may inspect or copy the protected health information to be disclosed under this permission to share.
- Finally, I understand that I may withdraw this permission in writing at any time by sending written notification to:

\_\_\_\_\_  
**(School/institution/individuals handling withdrawals must insert name and address)**

However, if I withdraw permission at a later date, any vaccine record already shared will not be covered by the withdrawal.

\_\_\_\_\_  
Printed name of Parent or Guardian

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Address

\_\_\_\_\_  
Date