HomeHealth Visiting Nurses
MaineHealth

H1N1 FORM
Preschool
CLINICS

HHVNU

PRINT CLEARLY. **Physicians Name** _____ **Children ages 6 months to 18 years**

LAST NAME:		**FIRST /NAME:**		**MIDDLE:**
ADDRESS:		**CITY:**	**STATE:**	**ZIP:**
BIRTH DATE:	**AGE:**	☐ **MALE** ☐ **FEMALE**	**PHONE #**	

Insurance Information

Name of Insurer:																	
Enter Insurance ID #																	

PLEASE			

SCREENING TOOL	YES	NO
▪ Has your child ever had a severe reaction to a previous seasonal influenza vaccine?	☐	☐
▪ Is your child allergic to eggs, chicken, gentamicin, gelatin, or arginine	☐	☐
▪ Does your child have a past history of Guillain-Barre Syndrome?	☐	☐
▪ Is your child sick with a fever?	☐	☐
STOP: If you answered yes to any of the above questions, your child cannot receive H1N1 vaccine. Contact your physician.		
▪ Does your child have asthma, lung disease, heart disease, diabetes, kidney problems, a blood disorder, immunodeficiency disease or are receiving aspirin or immunosuppressive therapies?	☐	☐
▪ Is your child in close contact with anyone who has a severely weakened immune system? (These people require care in a protected environment.)	☐	☐
▪ Has your child received any other vaccinations in the past 4 weeks? If child received MMR, Varicella or FluMist, they will require a flu shot. Date of vaccinations:	☐	☐
STOP: If you answered YES to any of the above 4 questions, your child will need a shot and should not get FluMist. Children aged 9 and under will require 2 doses of H1N1, 4 weeks apart.		
I give permission for my child to receive **injected** H1N1 influenza vaccine.	☐ INJECTED	
If you answered NO to all of the above questions, your child can receive either the shot or FluMist.		
I give permission for my child to receive intranasal H1N1 vaccine if appropriate.	☐ INTRANASAL OR INJECTED	

I have been provided a copy of the 2009 **H1N1 Vaccine Information Sheets** and had the opportunity to ask questions. I understand the benefits and risks of the influenza vaccine as described and ask that it be given to my child. I understand that if I consent to both types of the 2009 H1N1 vaccine, my child will be given the most appropriate vaccine, as determined by the health care provider giving the vaccination. I acknowledge that no guarantees have been made concerning the results of the vaccine. I hold harmless, HomeHealth Visiting Nurses its employees, and the facility in which the vaccine was received. I request that payment of authorized benefits be made on my behalf directly to HomeHealth Visiting Nurses.

X _____ ___

Parent or guardian signature Date

STAFF USE ONLY BELOW THIS LINE

VACCINE: circle: FluMist Injection ____ EXPIRES: _____NURSE'S SIGNATURE: _____

DATE: / /09 Lot # _____ Dose

Age 6mos – 35 mos 0.25ml Anterolaterol thigh site: ☐ Left ☐ Right

Age 3 yrs – 18 yrs 0.5ml Deltoid injection site : ☐ Left ☐ Right