

Dear Parents,

Vaccine against H1N1 Influenza (Swine flu) is beginning to arrive in New Mexico. Doctors are recommending that all children 6 months through 18 years of age be vaccinated against H1N1 influenza.

The New Mexico Department of Health is working with your child's school to **provide children with H1N1 Influenza vaccine at school**, so you won't need to miss work. We will plan for clinics as soon as the H1N1 vaccine is available.

H1N1 influenza vaccine comes in two forms: a nose spray and the shot. Both forms protect children well against the flu. If the nose spray form is available, children will be offered that vaccine, but the nurse will check if your child can get the spray based on the health questions you answer on the permission form.

H1N1 Influenza vaccine will be **FREE**. Children younger than ten years of age will need a second dose of H1N1 vaccine. A second clinic may be held later in the season for children who need a second dose of flu vaccine.

Please **fill out** and **sign** the accompanying form and **return to** _____
as soon as possible. Please returned signed form by: _____.

This signed form allows your child to receive two doses of H1N1 vaccine if appropriate. We are collecting insurance information on this form. If your child has insurance, we may seek to recover the costs of administering the vaccine through the insurance company. However, the vaccine will be administered at no cost, regardless of insurance status.

Together let's keep our children and our schools healthy and free from the flu!

If you have questions about the flu or flu vaccine, please call the H1N1 Hotline: 1-877- 304-4161. If you have questions about this consent form, please call:

_____.





H1N1 INFLUENZA (Swine Flu) IMMUNIZATION
School Consent Form (Please return to _____)
(PLEASE PRINT CLEARLY AND FIRMLY, INCOMPLETE FORMS WILL BE RETURNED)

Public Health Division

Student's Last Name: _____ First Name: _____ Middle Name: _____ Gender: (M / F)
 Date of Birth: _____ Age: _____ Grade: _____ Teacher: _____ Student ID: _____ Mother's Maiden Name: _____
 Current Mailing Address: _____ City: _____ Zip: _____ Home Phone: _____
 Race: (circle one) **AI/AN**-Am Indian/Alaska Native **A**-Asian **W**- White **B**-Black **O**-Other **Ethnicity: H** – Hispanic **NH** – Non-Hisp

INSURANCE INFORMATION

Medicaid/Salud (select): Pres Lovelace Molina Blue Cross/Blue Shield Policy # _____
 Private Insurance Co. _____ Policy # _____ Policy Holder's Name _____
 No Health Insurance Underinsured (Have commercial/private health insurance but coverage does not include vaccines, covers only selected vaccines, or insurance caps vaccine coverage at a certain amount.)

1. Is your child allergic to eggs? Yes No Don't Know
2. Has your child ever had Guillain-Barré syndrome (a type of temporary severe muscle weakness)? Yes No Don't Know
3. Has your child received a flu vaccination before? Yes No Don't Know
4. Has your child ever had a serious reaction to flu vaccine in the past? Yes No Don't Know
5. Has your child received any other vaccines in the past 4 weeks? Yes No Don't Know
 If yes, which one(s): _____ Date given: _____
6. Is your child allergic to gentamicin sulfate, gelatin or MSG? Yes No Don't Know
7. Does your child have asthma or other lung disease? Yes No Don't Know
8. Does your child have long-term health problems with heart disease? Yes No Don't Know
9. Does your child have kidney disease or renal dysfunction? Yes No Don't Know
10. Does your child have blood diseases (such as sickle cell anemia)? Yes No Don't Know
11. Does your child have diabetes? Yes No Don't Know
12. Is your child on long-term aspirin therapy? Yes No Don't Know
13. Does your child have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long term treatment with drugs such as steroids, or cancer treatment with x-rays or drugs? Yes No Don't Know
14. Is your child pregnant or planning to become pregnant in the next month? Yes No Don't Know
 Please list any allergies: _____

My child may receive H1N1 Influenza vaccine in whatever formulation is available and whatever is medically indicated.

I do not want my child to receive any H1N1 flu vaccine at school, because: _____

I have been given a copy and have read, or have had explained to me, the information in the "Vaccine Information Statements" for H1N1 influenza and the H1N1 influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the influenza vaccine requested and ask that the influenza vaccine be given to the person above for whom I am authorized to make the request. If the person above for whom I am authorized to make the request is less than 10 years old, I also request that a second dose of flu vaccine be given. I agree to report any problems that arise and direct any questions I may have to the school nurse.

I agree to allow information on this immunization given to the above-named person to be released to other medical care providers to avoid unnecessary vaccination or to ascertain immunization status. I also understand that my medical care provider may release this information to the state immunization registry (NMSIIS) unless I sign a document indicating my refusal.

Signature of parent/legal guardian _____ Date _____
 Print name of parent/legal guardian _____

FOR CLINIC USE (This section must be completed by the medical provider)

Vaccine	Date Vaccinated	Site of Injection/admin	Dose #	Vaccine Manufacturer	Lot Number	Provider Signature
2009 H1N1	/ /	<input type="checkbox"/> IM _____ <input type="checkbox"/> 0.25ml <input type="checkbox"/> 0.5 ml <input type="checkbox"/> Intranasal	<input type="checkbox"/> 1st <input type="checkbox"/> 2nd	<input type="checkbox"/> MedImmune (nasal spray) <input type="checkbox"/> SanofiPasteur <input type="checkbox"/> GSK * <input type="checkbox"/> Novartis <input type="checkbox"/> CSL	Lot # _____	_____
2009 H1N1	/ /	<input type="checkbox"/> IM _____ <input type="checkbox"/> 0.25ml <input type="checkbox"/> 0.5 ml <input type="checkbox"/> Intranasal	<input type="checkbox"/> 1st <input type="checkbox"/> 2nd	<input type="checkbox"/> MedImmune (nasal spray) <input type="checkbox"/> SanofiPasteur <input type="checkbox"/> GSK * <input type="checkbox"/> Novartis <input type="checkbox"/> CSL	Lot # _____	_____

* For 18 years and older only

Clinic ID# _____ NMSIIS entry completed