NEW MEXICO DEPARTMENT OF HEALTH

Public Health Division

**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 your school as soon as possible.**

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.**

Fall /Winter 2009

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

**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. <u>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</u>. 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 | / / | ❑ IM ________ ❑ 0.25ml ❑ 0.5 ml ❑ Intranasal | ❑ 1st ❑ 2nd | ❑MedImmune (nasal spray) ❑SanofiPasteur ❑GSK * ❑Novartis ❑CSL | Lot # ____________________ | ________________________ |
| 2009 H1N1 | / / | ❑ IM ________ ❑ 0.25ml ❑ 0.5 ml ❑ Intranasal | ❑ 1st ❑ 2nd | ❑MedImmune (nasal spray) ❑SanofiPasteur ❑GSK * ❑Novartis ❑CSL | Lot # ____________________ | ________________________ |

*** For 18 years and older only**

Clinic ID# ____________ NMSIIS entry completed ❑