

**RICHMOND COUNTY
HEALTH DEPARTMENT**

Visit our website at: publichealth.southernregionalahec.org/Richmond

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IMMUNIZATION PERMISSION FOR THE SCHOOL SITE 2009 H1N1 VACCINE

NAME OF SCHOOL YOUR CHILD ATTENDS: _____

FULL NAME OF STUDENT: (LAST) _____ (FIRST) _____ (MIDDLE) _____

DATE OF BIRTH: _____ RACE: _____ SEX: _____ STUDENT'S SS# _____ TELEPHONE # (Day) _____

ADDRESS: _____ CITY: _____ TELEPHONE # (Night) _____

PARENT/LEGAL GUARDIAN/LEGALLY RESPONSIBLE PERSON: _____ MOTHER'S MAIDEN NAME _____

If you would like for your child to receive the H1N1 vaccine at the school clinic, sign and date the following section below:

Yes, I want my child to have the H1N1 vaccine at the school clinic. I have been given the Vaccine Information Statement concerning the 2009 H1N1 influenza vaccine and understand the risks and benefits, and have been given a chance to ask questions.

I hereby give my permission for my child to receive the H1N1 vaccine.

Signature of Parent/Legal Guardian/Legally Responsible Person:

(x) _____

Date: _____

I hereby give my permission to the Richmond County Health Department to bill my insurance company for the administrative costs associated with this vaccine. I also understand that I am not responsible for any expenses, which are incurred and not paid by my insurance company for this service. **Although you will not be billed for this vaccine, the state of NC requires us to obtain the following personal data for statistical purposes only.**

Signature of Parent/Legal Guardian/Legally Responsible Person:

(x) _____ Date _____

Description of relationship to student: _____

TYPE OF INSURANCE COVERAGE ON CHILD:

[] Not insured [] Native American

[] Underinsured (has insurance but insurance does NOT cover immunizations

[] Medicaid Medicaid # _____

[] Insured Name of Insurance Company _____

Policy # _____ Group # _____

Name of Insured _____

Insured's DOB _____ Insured SS# _____

Address to send claims to _____

City _____ State _____ Zip _____

By signing below, I am acknowledging that:

- I am either the parent, legal guardian, or legally responsible person
- I have received a copy of the "Notice of Privacy Practices" for Richmond County Health Department; and
- I understand that I may contact the person named on the Privacy Notice if I have questions about the content of the Privacy Notice.

Signature of Parent/Legal Guardian/Legally Responsible Person:

(x) _____

Description of relationship to student:

Date: _____

DO NOT COMPLETE/FOR STAFF USE ONLY

Staff member sought but was unable to obtain an acknowledgment from the parent/legal guardian/Legally responsible person for the following reason:

[] Refused to sign [] Other (specify) _____

Signature of staff member _____

Date _____

If you DO NOT wish for my child to receive the H1N1 Vaccine at the school site immunization clinic, please sign and date below:

NO, I do not wish for my child to receive the H1N1 vaccine at his/her school.

Signature of Parent/Legal Guardian/Legally Responsible Person:

(x) _____

Description of relationship to student:

Date _____

**PLEASE
COMPLETE
QUESTIONNAIRE
ON REVERSE
SIDE OF THIS
SHEET.**

The following questions MUST be answered in order for your child to receive the H1N1 vaccination:

Please mark YES or NO for each of the following questions:

Question	YES	NO
1) Does your child have a serious allergy to eggs?		
2) Does your child have any other serious allergies that you know of? If YES, please list:		
3) Has your child ever had a serious reaction to a previous dose of flu vaccine?		
4) Has your child ever had Guillain-Barre Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?		
5) Has your child been vaccinated with any vaccine (not just flu) within the past 30 days? Vaccine: _____ Date given: month _____ day _____ year _____		
6) 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?		
7) Has your child had an episode of wheezing in the last 12 months?		
8) Is your child on long-term aspirin or aspirin-containing therapy (for example, does your child take aspirin every day)?		
9) Does your child have a weak immune system (for example, from 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)?		
10) Is your child pregnant or nursing a baby?		
11) 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)?		

FOR RCHD STAFF USE ONLY:

H1N1 Vaccine Mfg/Lot Number: _____

Injection Site: _____ Right Deltoid _____ Left Deltoid

Date: _____

Administered by: _____

LAIV (Flu Mist) Mfgr/Lot Number: _____

Date: _____

Administered by: _____

H1N1 Vaccine Mfg/Lot Number: _____

Injection Site: _____ Right Deltoid _____ Left Deltoid

Date: _____

Administered by: _____

LAIV (Flu Mist) Mfgr./LotNumber: _____

Date: _____

Administered by: _____