

## H1N1 Pediatric High Risk Screening Form

**Designated ONLY For Children 6 Months through 4 Years Old with Serious Health Conditions**

**Information about Individual to Receive vaccine (Please Print)**

Child's Name _____			Date of Birth (Month Day Year)	Age
(Last	First	MI)		
Primary Care Provider:			Primary Clinic:	
Address				
City	State	Zip	Daytime Phone Number:	

**Mark the box(es) that describe your child's serious health problems (examples are not all inclusive)**

- Lung problems (examples: asthma, cystic fibrosis, other )
- Heart problems (example: congenital heart disease, other )
- Kidney problems
- Liver problems
- Neurologic or neuromuscular diseases/problems (examples: seizure disorder, cerebral palsy, brain or spinal injuries, spina bifida, muscular dystrophy, others)
- Blood disorders: (example: sickle cell anemia, others)
- Diabetes or other metabolic disorders
- Developmental delay conditions (examples: mental retardation, Down's Syndrome, others)
- Immune compromised (example: cancer treatment, HIV, others)
- Other \_\_\_\_\_

Can your child receive the H1N1 Flu Vaccine?	Answer (circle)	
Does your child have a severe allergy to eggs?	Yes	No
Does your child have any <b>severe</b> allergies? List _____	Yes	No
Has your child ever had a bad reaction to the seasonal Flu shot/ nasalspray?	Yes	No
Has your child ever had Guillaine Barre Syndrome?	Yes	No
Is your child sick today?	Yes	No

**Consent for Vaccination**

*I agree that this information is correct to the best of my knowledge. I have received the 2009-2010 Vaccine Information Statement for H1N1 influenza and understand the risks and benefits. I understand that the information is confidential and will only be shared with organizations or persons who are authorized by law to receive it. This information will be included in the Minnesota Immunization Information Connection Registry, a secure Web-based registry system for health care providers. If you choose not to have your child's information shared in the registry please call 1-800-657-3970.*

Signature of person Receiving vaccine or Parent/Legal Guardian: \_\_\_\_\_

Sign: \_\_\_\_\_ Date \_\_\_\_\_

(vaccination will not be administered if the consent form is not signed and dated)

**For Administrative Use Only**

Vaccine H1N1	Date/ Administered VIS Given	Route <input type="checkbox"/> IM	Site:	Lot #	Manufacturer
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Name and Title of Vaccine Administrator \_\_\_\_\_