

Inactivated 2009 H1N1 Influenza Vaccine Questionnaire

Please answer the following questions about your child.

Child's Name

Date of Birth

1. Does your child have an allergy to chicken eggs or egg products? Yes No
2. Has your child ever had an allergic reaction to the influenza vaccine? Yes No
3. Does your child currently have a fever or is severely ill? Yes No
4. Does your child have a history of Guillain-Barré Syndrome? Yes No
5. My child is under 10 years old. Yes No
I understand that if my *child is under 10 years*, he/she should get 2 doses of the vaccine, 1 month apart. I will check in 1 month on the availability of receiving a second dose.
6. I have read and understand the information on the vaccine information statement provided and would like my child to receive the 2009 H1N1 influenza vaccine. Yes No

Signature of or Parent/Guardian

Date

Reviewed by _____, M.A, R.N, M.D.