

2009 Intranasal H1N1 Influenza Vaccine Questionnaire

Please answer the following questions about your child.

Child's Name _____

Date of Birth _____

1. Is your child 2 years or older? No Yes
2. Does your child have an allergy to chicken eggs or egg products? Yes No
3. Has your child ever had an allergic reaction to the influenza vaccine? Yes No
4. Does your child have a known or suspected disease or condition that weakens your immune system such as HIV infection, cancer, leukemia, lymphoma, agammaglobulinemia, or problems with your thymus? Yes No
5. Does your child live with someone who has a weakened immune system due to the reasons listed above? Yes No
6. Does your child presently taking medication or treatments that may weaken your immune system such as radiation, methotrexate, chemotherapy or other cancer treatment? Yes No
7. Does your child or adolescent regularly take aspirin or aspirin containing products? Yes No
8. Does your child have a history of Guillain-Barré Syndrome? Yes No
9. Does your child have a history of asthma, recurrent wheezing, reactive airway disease, or have a history of using Proventil or Albuterol? Yes No
10. Does your child have any underlying medical condition such as (but not limited to) chronic disorders of the lung and heart such as congestive heart failure or cardiomyopathy? Yes No
11. Does your child see a healthcare provider regularly because of a chronic illness such as diabetes, kidney problems, Hemoglobinopathy, or sickle cell disease? Yes No
12. Is your child/adolescent pregnant or nursing? Yes No
13. Has your child had an illness with symptoms of severe nasal congestion, sinus drainage, or fever within the last 3 days? Yes No
14. **Has your child received any vaccine within the last 30 days, including this year's seasonal influenza vaccine?** Yes No
15. My child is under 10 years old.
I understand that if my *child is under 10 years*, he/she should get 2 doses of the vaccine, 1 month apart. I will call in 1 month to check on the availability of receiving a second dose. Yes No
16. I have read and understand the information on the vaccine information statement provided and would like my child to receive the intranasal live attenuated H1N1 influenza vaccine. No Yes

Signature of or Parent/Guardian

Date _____

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