Lewiston Public Schools

36 Oak Street, Lewiston, ME 04240
(207) 795-4100
www.lewistonpublicschools.org

Lewiston School Dept. will be having **H1N1 (swine) influenza clinics** on the following dates:

Monday, Oct. 26 -	Farwell	Friday, Oct. 30 -	McMahon
Tuesday, Oct. 27 -	Longley	Monday, Nov. 2 -	LHS
Wednesday, Oct. 28 -	Montello	Tuesday, Nov. 3 -	LMS
Thursday, Oct. 29 -	Geiger	Wednesday, Nov. 4 -	Martel

Please read the vaccine information sheets attached to this letter. Once read, fill out both sides of the permission form and return to your school by **Thurs. Oct. 22nd**. If for some reason our school cannot hold the clinic on these dates, you will be notified when the clinics will occur. **Children under the age of 10 will need to have a booster dose three or more weeks after the first dose**. **A follow-up clinic will be set up in the schools for those needing a second vaccination**. Children older than age 10 will receive only one dose.

If you do not fill out this permission form completely, your child will not be given the vaccine. The information that you give on the Health Screen Form is vital in choosing which vaccine your child will receive. Please call the school nurse at your school if you have any questions. Parents are encouraged to attend these clinics with their child.

Please visit www.maineflu.gov or CDC's 2009 H1N1 influenza web sites at http://www.cdc.gov/h1n1flu/ and http://www.cdc.gov/h1n1flu/parents for more information especially for parents.

Sincerely,
The Lewiston School Department, The Maine CDC, and The Department of Education

H1N1 influenza vaccine permission form

I was given a copy of the 2009 H1N1 Vaccine Information Statements and I have read it or had it explained to me. I understand the benefits and the risks of the 2009 H1N1 Influenza Vaccination **and ask that the vaccine be given to my child.** I understand that if I consent to **both** types of vaccine, my child will be given the most appropriate vaccine, as determined by the health care provider giving the vaccination.

I give permission for my child to receive **intranasa**l H1N1 influenza vaccine **if appropriate.** ☐ yes ☐ no

OR

I give permission for my child to receive **injected** H1N1 influenza vaccine. ☐ yes ☐ no

Signature of Parent or Guardian:_______________________________________ Date:_______________

Parent or Guardian Name (please print): ____

Lewiston School Department 2009 H1N1 Influenza Vaccine Clinic

STUDENT NAME:_________________________________ BIRTHDATE:____________ AGE:___

ADDRESS:____________________________________CITY:___________

TELEPHONE:____________________

Please provide a phone number where you can be reached on the day of the clinic: ____________________

SCHOOL:_________________________ GRADE:_______ TEACHER:________________________

HEALTH SCREEN

The following questions will help us determine if there is any reason your child should not receive the H1N1 influenza vaccination on clinic day. Please answer every question.

1.) Does this child have an allergy to eggs? YES NO

2.) Does this child have any other serious allergies that you know of? (please list) YES NO

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3.) Has this child ever had a serious reaction to immunizations in the past? YES NO

4.) Has this child ever had Guillain-Barre Syndrome? YES NO

There are two kinds of 2009 H1N1 influenza vaccine. Your answers to the following questions will help us know which of the two kinds of vaccine your child can get.

1.) Has this child been vaccinated with **any** vaccine (not just flu) within the past 30 days? YES NO
Vaccine: __________________________________ Date given: month_____ day____ year______

2.) Does this 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? YES NO

3.) Is this child on long-term aspirin or aspirin-containing therapy (for example, does your child take aspirin every day)? YES NO

4.) Does this child have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)? YES NO

5.) Could this child be pregnant? YES NO

6.) Does this 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)? YES NO

I give permission for this form to be sent to my child's primary care provider YES NO

Name of child's health care provider (doctor, nurse practitioner): _________________________________

Phone number of child's health care provider: _____________________

FOR OFFICE USE ONLY:

Vaccine	Date Dose Administered	Route	Dose Number (1st or 2nd)	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator
2009 H1N1	/ /	☐ IM ☐ Intranasal				
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