

# Lewiston Public Schools

36 Oak Street, Lewiston, ME 04240

(207) 795-4100

[www.lewistonpublicschools.org](http://www.lewistonpublicschools.org)

Martel School will continue to offer H1N1 (swine) flu vaccinations during the school day. Please read the vaccine information sheets attached to this letter. Once you have read the information sheets, fill out **both sides** of the permission form and return it to the school. Your child will be added to the list for immunization. **If your child receives the vaccine at their doctor's office, please notify the school so we can remove your child's name from the list.** Children under the age of 10 will need to have a booster dose three or more weeks after the first dose and we will provide that booster at the school. Children older than age 10 will receive only one dose. **If you do not fill out both sides of this permission form completely, your child will not be given the vaccine.**

You may find more information about H1N1 flu and the vaccine at [www.maine flu.gov](http://www.maine flu.gov), [www.flu.gov](http://www.flu.gov), and [www.cdc.gov/h1n1flu/parents](http://www.cdc.gov/h1n1flu/parents). If you have questions about H1N1 flu or the vaccine, call Maine CDC at 1-888-257-0990 Monday – Friday 9 a.m. – 5 p.m., or send an e-mail to [flu.questions@maine.gov](mailto:flu.questions@maine.gov).

If you have questions, please call the Martel School nurse at 795-4130.

*OPTIONAL: Parents are encouraged to attend these clinics with their child.*

Sincerely,

The Lewiston School Department

## **H1N1 influenza vaccine permission form**

I was given a copy of the 2009 H1N1 Vaccine Information Statements and I have read them, or had them 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 sign below, I am giving my consent, and my child will be given the most appropriate vaccine, as determined by the health care provider giving the vaccination.

Signature of Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Guardian Name (please print): \_\_\_\_\_

*Please be sure to complete and return the information on page 2 of this letter.*

**Lewiston Public Schools 2009 H1N1 Influenza Vaccine Clinic**

SCHOOL NAME: \_\_\_\_\_

STUDENT NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ AGE \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_

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

**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  
\_\_\_\_\_
- 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

Health Insurance Company (if any) and Number: \_\_\_\_\_

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 (1 <sup>st</sup> or 2 <sup>nd</sup> )	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator
2009 H1N1	/ /	<input type="checkbox"/> IM <input type="checkbox"/> Intranasal				
2009 H1N1	/ /	<input type="checkbox"/> IM <input type="checkbox"/> Intranasal				