

FOR OFFICE USE

VFC-IM

Private-IM

2016 Influenza Vaccine School Consent Form
Barron County DHHS Public Health

| | | | | | | |
|-------------------------------------|-------|---------|--------|--|---------|-----------------|
| STUDENT'S NAME (Last) | | (First) | (M.I.) | GRADE | TEACHER | |
| PARENT/LEGAL GUARDIAN'S NAME (Last) | | (First) | (M.I.) | STUDENT'S BIRTH DATE (mm/dd/yyyy) / / | AGE | GENDER M / F |
| ADDRESS | | | | PARENT/GUARDIAN DAYTIME PHONE NUMBER: | | |
| CITY | STATE | ZIP | SCHOOL | | | |

Please answer the following questions by circling "YES" or "NO". We need this important health information to determine if your child should receive this vaccine.

| | | |
|--|-----|----|
| Does your child have a serious allergy to eggs? | YES | NO |
| Does your child have any other serious allergies? Please list: _____ | YES | NO |
| Has your child ever had a serious reaction to a previous dose of flu vaccine? | YES | NO |
| Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine? | YES | NO |
| Has your child been vaccinated with any vaccine (not just flu) within the past 30 days? If yes, please indicate type and date. Vaccine: _____ Date given: month _____ day _____ year _____ | YES | NO |
| Did your child receive influenza vaccine last year? If yes, circle how many doses your child received? Doses 1 2 | YES | NO |

Please circle "YES" or "NO" for each consent item, complete insurance information and sign below. Your child will not receive influenza vaccination without a parent or guardian signature.

| | | |
|--|-----|----|
| 1. I have read the 2016-2017 Vaccine Information Statement for the influenza vaccine and understand the risks and benefits. This consent allows for the Barron County Public Health to administer influenza vaccine to the child listed above. | YES | NO |
| 2. I consent to sharing influenza immunization data with the Wisconsin Immunization Registry (WIR) so that my clinic/physician is aware that my child received this vaccine. | YES | NO |
| 3. Please circle the best description of your child's health insurance coverage: Badger Care health insurance Health Insurance, vaccines covered Health Insurance, vaccines not covered No | | |

Parent or Guardian Signature: _____ **Date:** _____

| Date Dose Administered | Route | IM Site | Vaccine Manufacturer | Lot Number | Name and Title of Vaccine Administrator |
|------------------------|-----------------------------|--|----------------------|------------|---|
| | <input type="checkbox"/> IM | <input type="checkbox"/> LD <input type="checkbox"/> RD | | | |