Do NOT return if you don't want your child to get vaccinated.

GRANT COUNTY HEALTH DEPARTMENT - 2015-16 INFLUENZA VACCINE CONSENT FORM

Information collected on this form will be used to document permission for receipt of 2015-16 influenza vaccine. Record of this immunization may be shared through the Wisconsin Immunization Registry (WIR) with other health care providers already directly involved with the vaccinated person's care.

Grade

PLEASE PRINT: **(Last, First, Middle Initial)** **CHILD'S NAME:**	☐ Male ☐ Female

Birthdate	Age	Telephone Number:
Month_____ Day_____ Year_____		

Street Address:	City	State	Zip Code	County
		WI		Grant

All students will receive Flu Mist Intranasal vaccine as supplies last unless it is not advised medically. If you have questions or concerns, feel free to call the Grant County Health Department at (608) 723-6416.

Fill out form about person receiving vaccine.

YES	NO	1. Has the person had a serious reaction to a vaccine in the past?
YES	NO	2. Does the person have any of the following (heart disease, lung disease, asthma, kidney or liver disease or diabetes?
YES	NO	3. Does the person receive long-term aspirin treatment?
YES	NO	4. Does the person have a serious allergy to eggs?
YES	NO	5. Has the person had a seizure or brain problem?
YES	NO	6. Is the person pregnant?
YES	NO	7. Does the person have a weakened immune system or live with someone whose immune system is so weak they receive care in a protected environment (i.e. bone marrow transplant unit)?
YES	NO	8. Has the child had any vaccinations in the last 4 weeks. (If yes, list vaccines_____)

CONSENT FOR VACCINATION:

-I have read, or have had explained to me, the Vaccine Information Statement for influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and the risks of the vaccine requested and ask that the vaccine be given to the person named above for whom I am authorized to make this request. I consent to have my protected health information used for treatment, payment, and health care operations. Information may be shared through the WIR (Wisconsin Immunization Registry).

-Wisconsin Medicaid restricts billing recipients for any covered service(s). I understand that if I am a Medicaid/BadgerCare recipient I cannot be charged an administration fee or asked for any type of donation for the administration of any vaccine that is being provided.

-I give permission to share my child's immunization records including those provided to School(s) with the Wisconsin Immunization Registry and my Immunization Provider for the purpose of maintaining a complete and accurate record to assist in assuring full immunization.

☐ Check here if you do NOT want your child's immunization recorded in WIR.

Signature of Parent/Guardian:_____ **Date**_____

OFFICE USE ONLY:

NASAL	INJECTABLE	Right Deltoid
☐ MedImmune (Nasal) _____	☐ Sanofi Pasteur Fluzone_____	

Date Vaccinated:	Signature & Title of Vaccine Adminstrator:	Registered Nurse