ST. CROIX COUNTY Public Health
Protect, Promote, Prevent

Authorization to Receive Vaccine(s)

Information collected on this form will be used to document authorization for receipt of vaccinations at your child's school. Information may be shared through the Wisconsin Immunization Registry (WIR) with other health care providers directly involved with your child to assure completion of the vaccine schedule.

My signature below authorizes my child to receive these vaccinations. Check all that apply:	☐ Tdap (Tetanus, diphtheria, acellular pertussis) vaccine ☐ Meningococcal ☐ Human papillomavirus (HPV)	**CHOOSE ONE:** ☐Influenza Nasal ☐Influenza Injectable

Patient's Name (Last, First, Middle Initial) | Mother's Maiden Name (Last, First, Middle Initial)

Address | City | County | State | Zip Code

Home Telephone Number ( ) | Date of Birth (mm/dd/yyyy) | Gender ☐ Male ☐ Female

Race (Check one)
☐ African America ☐ American Indian or Alaskan Native
☐ Asian ☐ Native Hawaiian/Pacific
☐ White ☐ Other

Ethnicity (Check one)
☐ Hispanic or Latino
☐ Non-Hispanic or Latino

Eligibility Status – This section must be completed (check all that apply).
☐ Native American ☐ BadgerCare Plus ☐ Insured, Vaccines Covered
☐ Medicaid Eligible ☐ No Health Insurance ☐ Insured, Vaccine Not Covered

Name of Physician | Name of School | Grade

Name of Parent/Guardian Responsible for Patient (Last, First, M.I.) | Relationship to Patient

Okay to share immunization data with the Wisconsin Immunization Registry (WIR)?
☐ Yes ☐ No

I have been given a copy and have read, or have had explained to me, information about the disease(s) and vaccine(s) to be received. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine(s) be given to the person above whom I am authorized to make this request. **Wisconsin Medicaid restricts billing recipients for any covered service(s).** I understand that if the above named is 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.

SIGNATURE – ***Person authorized to sign on patient's behalf.*** | **Date**

X

FOR OFFICE USE

Vaccine ______________________ IN IM SQ (circle one) RD or LD dose (circle one) – 1 or 2 Staff Initials
Manufacturer ________________________________ Lot No. ________________________ VIS date: __________

Vaccine ______________________ IN IM SQ (circle one) RD or LD dose (circle one) – 1 or 2
Manufacturer ________________________________ Lot No. ________________________ VIS date: __________

Vaccine ______________________ IN IM SQ (circle one) RD or LD dose (circle one) – 1 or 2
Manufacturer ________________________________ Lot No. ________________________ VIS date: __________

Vaccine ______________________ IN IM SQ (circle one) RD or LD dose (circle one) – 1 or 2
Manufacturer ________________________________ Lot No. ________________________ VIS date: __________

Signature(s) of person(s) administering vaccine: ________________________ Date: __________ Clinic Site: ____________

____

Fill in other side and sign →

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Screening Checklist for Contraindications to Vaccination:

For parents/guardians: The following questions will help us to determine which vaccines your child may be given. If you answer "yes" to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions might need to be asked.

1. Is the person to be vaccinated sick today? ☐ Yes ☐ No

2. Does the person to be vaccinated have allergies to medications, eggs, yeast, latex, or any component of vaccines they have had in the past? ☐ Yes ☐ No

3. Has the person to be vaccinated ever had a serious reaction to a vaccine in the past? ☐ Yes ☐ No

4. Has the person to be vaccinated ever had Guillain-Barré syndrome? ☐ Yes ☐ No

5. Has the person to be vaccinated had a long-term health problem with lung, heart, kidney, liver, or metabolic disease (e.g. diabetes), asthma, neurologic or neuromuscular disease, anemia or another blood disorder? Is he/she on long-term aspirin therapy? ☐ Yes ☐ No

6. Is the person to be vaccinated younger than age 2 years or older than age 49 years? ☐ Yes ☐ No

7. If the person to be vaccinated is a child age 2 through 4 years, in the past 12 months, has a healthcare provider told you the child had wheezing or asthma? ☐ Yes ☐ No

8. Does the person to be vaccinated have cancer, leukemia, HIV/AIDS, or any other immune system problem; or, in the past 3 months, have they taken medications that weaken the immune system, such as cortisone, Prednisone, other steroids, or anticancer drugs; or have they had radiation treatments? ☐ Yes ☐ No

9. Is the person to be vaccinated pregnant or could she become pregnant within the next month? ☐ Yes ☐ No

10. Is the person to be vaccinated currently receiving antiviral medications? ☐ Yes ☐ No

11. Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g., an isolation room of a bone marrow transplant unit)? ☐ Yes ☐ No

12. Has the person to be vaccinated received any other vaccinations in the past 4 weeks? ☐ Yes ☐ No

13. Has the person to be vaccinated had a seizure or any brain or other nervous system problems? ☐ Yes ☐ No

14. Has the person to be vaccinated received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug in the past year? ☐ Yes ☐ No

X Form completed by: ____ Date:___________________________

(parent or guardian)

Form reviewed by: ____ Date:___________________________

Fill in other side and sign →