



Influenza Vaccine Consent Form

CHILD'S NAME (Last)	(First)	(M.I.)	GRADE	TEACHER	
PARENT/LEGAL GUARDIAN'S NAME (Last)	(First)	(M.I.)	CHILD'S BIRTH DATE MM/DD/YY ____/____/____	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 and what type of vaccine they can receive.

1. Does your child have a serious allergy to eggs?	YES	NO
2. Does your child have any other serious allergies? Please list:	YES	NO
3. Has your child ever had a serious reaction to a previous dose of flu vaccine?	YES	NO
4. 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
5. Is your child pregnant?	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 consent to sharing influenza immunization data with the Wisconsin Immunization Registry (WIR) so that my clinic/physician is aware that my child has received this vaccine.	YES	NO
2. Please circle the best description of your child's health insurance coverage: Badger Care Health Insurance Vaccines covered by Health Insurance Vaccines not covered No health insurance		

I have read the Vaccine Information Statements for the influenza vaccine and understand the risks and benefits. By signing this consent form, I give permission to the St. Croix County Health Department to administer influenza vaccine to the child listed above.

Parent or Guardian Signature: _____ Date: _____

Date Dose Administered	Route	IM Site	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator
	IM	LD RD			