




FLU VACCINE CONSENT FORM

- ☐ YES, give my child the Flu Mist (nasal spray)  **Fill out Section 1, 2 & 3 and return form to school**
- ☐ YES, give my child the Flu Shot (in the arm)  **Fill out Section 1, 2 & 3 and return form to school**
- ☐ No, I do not want my child to receive the Flu vaccine  **Fill out Section 1 only & return form to school**

SECTION 1

Student Name (Last, First, Middle initial) please print			Male	Female
Date of Birth	Age	Parent/Guardian Name	Telephone Number ()	
Address		City	County	State Zip Code
Does your child have?	<input type="checkbox"/> Badger Care <input type="checkbox"/> No Health Insurance	<input type="checkbox"/> Insured, Vaccines Covered <input type="checkbox"/> Insured, Vaccines Not Covered	<input type="checkbox"/> Native American Heritage	
School	Teacher	Grade		

Please Circle Yes or No

SECTION 2

Does your child have allergies to medications, eggs, or any vaccines? List: _____	YES	NO
Has your child ever had Guillian Barre syndrome?	YES	NO
Has your child ever had a serious reaction to past flu vaccinations?	YES	NO
Has your child ever had a history of wheezing or asthma?	YES	NO
Does your child have diabetes or disease of the heart, lung, kidney, liver, nerves or blood?	YES	NO
Does your child receive long-term aspirin or aspirin-containing therapy?	YES	NO
Does your child have a weakened immune system (HIV, cancer, or medications such as steroids)?	YES	NO
Is the person to receive the vaccine pregnant?	YES	NO
Does your child have close contact with a person whose immune system is severely compromised and who must be in a protective isolation (such as in a hospital room with reverse air flow)?	YES	NO
Has your child received any vaccinations in the past 4 weeks? List: _____	YES	NO

SECTION 3

CONSENT FOR VACCINATION: I have read, or have had explained to me, the Vaccine Information Statement for influenza vaccine (www.OCPH.info). 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 be given the person named above for whom I am authorized to make this request. Oconto County Health Department will bill Medical Assistance/BadgerCare if the child is covered by those programs. I understand that a record of this immunization may be shared through the Wisconsin Immunization Registry (WIR) and with other health care providers directly involved with the vaccinated person's care. This consent form authorizes the administration of multiple doses of a vaccine, if medically indicated. This consent form will expire after the last vaccination is given in a vaccine series.

Signature X _____ Date _____

FOR OFFICE USE:

Is the child well today? YES NO

VIS date: 2012-2013

Route IM IN Body site RD RV LD LV IN Dose 1 2

Manufacturer _____ Lot No: _____

Signature/Title of person administering vaccine _____ Date vaccine administered _____