

Do Not Complete This Form If You Do Not Want Your Child to Receive The Influenza Vaccine

2020 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 within the past 30 days? If yes, please indicate type and date. Vaccine: _____ Date given: month____day____year_____	YES	NO
Has your child been vaccinated for influenza this year? 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
I have read the Vaccine Information Statement for the influenza vaccine and understand the risks and benefits.	YES	NO

Your child's vaccination record, including those provided at/to School(s) will be shared with the Wisconsin Immunization Registry (WIR) and Wisconsin Immunization Providers for the purpose of maintaining a complete and accurate record to assist in assuring full immunization. **Please contact Public Health at 715-537-5691 ext 6442, prior to the date your child will be vaccinated if you do not wish to have your child's immunization record shared.**

Please check the best description of your child's health insurance coverage:

- Badger Care**
- Health Insurance, vaccines covered**
- Health Insurance, vaccines not covered**
- No Health Insurance**

Your child will not receive the influenza vaccination without a parent or guardian signature.

Signing this consent allows Barron County Public Health 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
	<input type="checkbox"/> IM	<input type="checkbox"/> LD			
	<input type="checkbox"/>	<input type="checkbox"/> RD			