2017 Influenza Vaccine School Consent Form

Polk County Health Department

For Office Use	
Private	VFC

STUDENT'S NAME (Last)	(First)	(M.I.)	**GRADE**	**TEACHER/ADVISOR**		
PARENT/LEGAL GUARDIAN'S NAME (Last)	(First)	(M.I.)	**STUDENT'S BIRTH DATE (m/d/y)** / /	**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. ONLY THE INJECTABLE VACCINE (THE SHOT) IS AVAILABLE.

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

Please circle "YES" or "NO" for insurance billing consent. Complete insurance information or attach a copy of insurance card.

1. Please **circle** the best description of your child's health insurance coverage:

   Health Insurance, vaccines covered **Health Insurance, vaccines not covered**

   No health insurance **Badger Care**

2. **If my child is covered by health insurance (including Badger Care)**, I consent to allow the Polk County Health Department to bill my insurance company for the administration of influenza vaccine. **Please complete this section or attach a copy of your child's insurance card.** YES NO

Name of Health Insurance Plan/Company:

_____

Group # _____ Child's ID#_____

Subscriber's Name (print) _____

Consent to Vaccinate & Share Records: Your child will not receive influenza vaccination without a parent or guardian signature below.

DO NOT COMPLETE THIS FORM IF YOU DO NOT WANT YOUR CHILD VACCINATED.

I have read the Vaccine Information Statement for the influenza vaccine and understand the risks and benefits. By signing this consent form I give permission to the Polk County Health Department to administer influenza vaccine to the child listed above. I give permission to share my child's immunization records with the Wisconsin Immunization Registry (WIR) for the purpose of maintaining a complete and accurate immunization record.

Check here ONLY if you do not give permission to share your child's immunization record with WIR. ☐

Parent or Guardian Signature: _____ Date: _____

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