

FLU VACCINE CONSENT FORM

CHECK ONLY ONE

Give my child the FluMist (nasal spray)

Fill out form and return to school

Give my child the Flu shot (in the arm)

Student Name (Last, First, Middle initial) please print			Male	Female
Date of Birth	Age	Parent/Guardian Name	Telephone Number	
Address		City	State	Zip Code
Race (person to be vaccinated): <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Black/African American <input type="checkbox"/> Other Race				
Does your child have? <input type="checkbox"/> Insured, Vaccines Covered <input type="checkbox"/> Native American Heritage <input type="checkbox"/> No Health Insurance <input type="checkbox"/> Insured, Vaccines Not Covered <input type="checkbox"/> MA/Badger Care				
School /Address	Grade	if 4k please indicate AM PM	Teacher	

Circle Yes or No

Does the child have any allergies to medications, food, a vaccine component or latex? List: _____.	Yes	No
Has the child had a serious reaction to a vaccine in the past?	Yes	No
Has the child had a health problem with heart, lung (including asthma), kidney, liver, metabolic disease (e.g. diabetes), or blood disorder?	Yes	No
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? <i>If yes, NOT eligible for FluMist.</i>	Yes	No
Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	Yes	No
Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems? Has the child ever had Guillain-Barre syndrome?	Yes	No
In the past 3 months, has the child taken medications that affect the immune system, such as cortisone, prednisone, other steroids, anticancer drugs; or had radiation treatments?	Yes	No
Has the child received influenza antiviral medications in the last 14 days?	Yes	No
Is the child receiving aspirin therapy or aspirin-containing therapy?	Yes	No
Is the person to be vaccinated pregnant or could she become pregnant within the next month?	Yes	No
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
Has the child received any vaccination in the past 4 weeks? List: _____	Yes	No

CONSENT FOR VACCINATION: I have read, or have had explained to me, the Vaccine Information Statement for the 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 requested and ask that the Flu vaccine be given to the person named above for whom I am authorized to make this request. Oconto County Public 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. A copy of this consent form is as valid as the original.

Signature X _____ **Date** _____

Data Entry _____ / _____

Billing _____ / _____

WIR _____ / _____

Office Use Only



Is child well today? Y N Route IM Nasal Body site RD LD _____

Vaccine Administrator Signature/Title _____ Date: _____

Lot#/MFG/Exp. Date Label

Notes:
