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): ☐ American Indian or Alaska Native ☐ Asian ☐ White ☐ Native Hawaiian or other Pacific Islander ☐ Black/African American ☐ Other Race			
Does your child have? ☐ Insured, Vaccines Covered ☐ Native American Heritage ☐ No Health Insurance ☐ Insured, Vaccines Not Covered ☐ 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? ***If yes, NOT eligible for FluMist.***	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 may issue a claim for billable services to Forward Health or my insurance company, however I will not be billed for any charges not covered by my insurance company. 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:

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VIS Influenza Inactivated 08/06/21 VIS Live Influenza 08/06/21