Do NOT return if you don't want your child to get vaccinated.

GRANT COUNTY HEALTH DEPT 2023-2024 INFLUENZA VACCINE CONSENT FORM

Information collected on this form will be used to document permission for receipt of **2023/2024** influenza vaccine. Record of this immunization may be shared through the Wisconsin Immunization Registry (WIR) with other health care providers already directly involved with the vaccinated person's care.

School:	Grade/Teacher

PLEASE PRINT: (Last, First, Middle Initial) **CHILD'S NAME:**				☐ Male ☐ Female
Birthdate Month____ Day____ Year____	**Age**	**Parent/Guardian Name:**		
Street Address:		**State** WI	**County**	**Telephone Number:**
City		**Zip Code**	Grant	**Email Address:**

All students will receive injectable vaccine. If you have questions or concerns, feel free to call the Grant County Health Department at (608) 723-6416.

Fill out form about person receiving vaccine.

YES	NO	1. Has the person had a serious reaction to a vaccine in the past?
YES	NO	2. Does the person have any of the following (heart disease, lung disease, asthma, kidney or liver disease or diabetes?
YES	NO	3. Does the person receive long-term aspirin treatment?
YES	NO	4. Does the person have a serious allergy to eggs?
YES	NO	5. Has the person had a seizure or brain problem?
YES	NO	6. Is the person pregnant?
YES	NO	7. Does the person have a weakened immune system or live with someone whose immune system is so weak they receive care in a protected environment (i.e. bone marrow transplant unit)?
YES	NO	8. Has the person had any vaccinations in the last 4 weeks. (If yes, list vaccines_____)

CONSENT FOR VACCINATION:

-I have received, read, or have had explained to me, the Vaccine Information Statement for influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and the risks of the vaccine requested and ask that the vaccine be given to the person named above for whom I am authorized to make this request. I consent to have my protected health information used for treatment, payment, and health care operations. Information may be shared through the WIR (Wisconsin Immunization Registry).

-Wisconsin Medicaid restricts billing recipients for any covered service(s). I understand that if I am a Medicaid/BadgerCare recipient I cannot be charged an administration fee or asked for any type of donation for the administration of any vaccine that is being provided.

-I give permission to share my child's immunization records including those provided to School(s) with the Wisconsin Immunization Registry and my Immunization Provider for the purpose of maintaining a complete and accurate record to assist in assuring full immunization. ☐ Check here if you do NOT want your child's immunization recorded in WIR

Signature of Parent/Guardian:_____ **Date**_____

OFFICE USE ONLY:

INJECTABLE — Right Deltoid, IM

☒ **GSK Flulaval Quadrivalent P-Free 7A5C3 Expires 6/30/24** — VIS: 8/6/21)

Date Vaccinated:	**Signature & Title of Vaccine Adminstrator:**	Registered Nurse