2024-2025 Authorization to Receive the following Vaccines: **Tetanus, diphtheria, acellular pertussis (Tdap)**
Meningococcal Conjugate (MCV4)
Human Papillomavirus (HPV)
Grant County Health Department **Influenza**

Information collected on this form will be used to document authorization for receipt of Tdap, MCV4, HPV and Influenza vaccine(s) at your child's school. Information may be shared through the Wisconsin Immunization Registry (WIR) with other health care providers directly involved with your child to assure completion of the vaccine schedule.

My signature below authorizes my child to receive these vaccine(s):
Check all that apply: →

- ☐ Tdap (Tetanus, diphtheria, acellular pertussis)(Boostrix) vaccine [**Required** (1 dose)]
- ☐ MVC4 (Meningococcal conjugate) (MenQuadfi) vaccine [**Required** (2 dose)]
- ☐ HPV (Human Papillomavirus)(Gardasil)vaccine[**Recommended** (2 or 3 dose series)]
- ☐ Influenza vaccine [**Recommended** seasonally (1 dose)]

Patient's Name (Last, First, Middle Initial)	Mother's Maiden Name (Last, First, Middle Initial)

Address	P. O. Box	City	County	State	Zip Code

Home Telephone Number ( )	Date of Birth (mm/dd/yyyy)	Gender ☐ Male ☐ Female

Race (Check one)
☐ African American ☐ American Indian or Alaskan Native ☐ Asian
☐ Native Hawaiian / Pacific ☐ White ☐ Other

Ethnicity (Check one)
☐ Hispanic or Latino
☐ Non-Hispanic or Latino

Eligibility Status - This section must be completed. (Check all that apply)

☐ **Native American** ☐ **Badger Care** ☐ **Insured, Vaccines Covered**
☐ **Medicaid Eligible** ☐ **No Health Insurance** ☐ **Insured, Vaccines Not Covered**

Name of Physician	Name of School	Grade/Teacher

Name of Parent or Guardian Responsible for Patient (Last, First, Middle Initial)	Relationship to Patient

Okay to share immunization data with Wisconsin Immunization Registry (WIR)?
☐ Yes ☐ No

I have been given a copy and have read, or have had explained to me, information about the disease(s) and vaccine(s) to be received. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine(s) be given to me or to the person named above for whom I am authorized to make this request.

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.

SIGNATURE - Person to receive vaccine or person authorized to sign on the patient's behalf. **X**	Date Signed

FOR OFFICE USE:

☐ **Tdap (Boostrix)** (RightArm)	☐ **MCV4 (MenQuadfi)** (Left Arm)	☐ **HPV (Gardasil 9)** (Right Arm)	☐ **Influenza** (Right Arm)
LOT: EXP: VIS: 8/06/2021	Lot: U7459AE Exp: 11/03/2024 VIS: 8/06/2021	Lot: W012141 Exp: 11/09/2024 VIS: 8/06/2021	Preservative Free Lot: 495MK Exp: 06/30/2024 VIS: 8/06/2021

Signature and title of person administering vaccine:_____ Date vaccine administered: _____