Office Visit/School Clinic (Injectable)

2023-2024 SEASONAL INFLUENZA VACCINE CONSENT FORM

Information collected on this form will be used to document permission for your child to receive the 2023-2024 seasonal influenza vaccine at your child's school. Record of this immunization may be shared through the Wisconsin Immunization Registry (WIR) with other health care providers directly involved with your child's care.

SCHOOL: _____ **City** _____

Student's Name (Last, First, Middle initial)			**Gender** ☐ Male ☐ Female
Student's Birthdate Month _____ Day _____ Year _____	**Student's Age**	**School Grade**	**Parent/Guardian Daytime Phone Number** ( )
Home Address	**P. O. Box**	**City**	**County** **State** **Zip Code**
Parent/Guardian's Name	**Okay to share the seasonal influenza immunization data with the Wisconsin Immunization Registry (WIR)?** ☐ Yes ☐ No		

Please answer the following questions (circle Yes or No):

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 or allergic response to past flu vaccinations?	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

CONSENT FOR CHILD'S VACCINATION:

I have read, or have had explained to me, the Vaccine Information Statement (VIS) for influenza vaccine. 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 vaccine be given to the student named above for whom I am authorized to make this request.

Signature **X**_____ Date _____

BILLING INFORMATION

_____Medicare Part B _____Medicaid _____GLHP/Senior Preferred _____School Insurance

_____Private Pay _____Other Insurance

Insurance Name:_____ Subscriber/Member ID Number:_____

Group Number: _____ Relationship to Insured: _____Self _____Spouse _____Child _____Other

FOR OFFICE USE VIS date: 8/6/21

Clinic/Office Address _____Viroqua Area Schools_____

2023-2024 Seasonal Flu: Route (circle one) = IM Body site (circle one) = RD or LD Dose (circle one): 1 or 2

Manufacturer _____ Lot No._____

Signature and title of person administering vaccine: _____

Date vaccine administered: _____

Vernon County Health Department
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Viroqua, WI 54665-0209