Winnebago County Health Department
112 Otter Ave
Oshkosh, WI 54903-2808

School Influenza Clinic Consent Form
FOR 3K THROUGH 12th GRADE
Authorization to Receive 2018-2019
Inactivated influenza Vaccine (Injectable)

PublicHealth
Prevent. Promote. Protect.
Winnebago County Health Department

Information collected on this form will be used to document authorization for receipt of the injectable influenza vaccine (flu shot) 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.

Child's Name ---------- ***PLEASE PRINT CLEARLY WITH PEN*** ----------			*Date of Birth (mm-dd-yyyy)* - -
Last:	First:	Middle:	
Street Address:			Gender ☐ Male ☐Female
City	State	Zip Code	Telephone Number ( )
Race (Check One) ☐Native American or Alaska Native ☐Other ☐Native Hawaiian or Other Pacific Islander ☐Asian ☐White ☐Black or African American			Ethnicity (check one) ☐Hispanic ☐Non-Hispanic
Mother's Maiden Name (Last, First)	Name of School:	Grade	K- 6 Teacher:
Name of Parent or Guardian Responsible for Child if under 18: (Last, First Middle)			Relationship to child:

Please answer the following questions so we can determine if your child can receive the 2018-2019 influenza vaccine (flu shot).

☐ Yes ☐ No Does your child have a serious allergy to eggs?

☐ Yes ☐ No Has your child ever had a serious reaction to a previous dose of flu vaccine?

☐ Yes ☐ No Has your child ever had Guillain-Barre Syndrome (a type of temporary severe muscle weakness)?

☐ Yes ☐ No I give my permission for my child to be held during administration of the vaccine if necessary.

Other comments from parent/legal guardian:

I have read, or have had explained to me the Vaccine Information Statement for inactivated 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(s) requested and ask that the vaccine be given by the Winnebago County Health Department to the person named above, for whom I am authorized to make this request. **If my child is younger than 9 years of age, this consent authorizes the second dose of influenza vaccine if medically indicated.** Consent can be revoked by notifying the Winnebago County Health Department at (920)232-3000.

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 give your permission to share: ☐

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

NOTES: For School/Health Department staff:	
DOSE #1 Date: _____ ***IM: RD LD RV LV***	***DOSE #2 Date:*** _____ ***IM: RD LD RV LV***
Manufacturer_____ Lot #_____	Manufacturer_____ Lot #_____
SIGNATURE: _____, RN	SIGNATURE: _____, RN