2020-2021
Vaccine Consent Record – Ashland County Health and Human Services Department
Mass Immunization Clinic

630 Sanborn Ave. Ashland, WI 54806

Information collected on this form will be used to document authorization for receipt of Influenza vaccine 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:

☐ **Influenza Vaccine**
⇒ Recommended yearly

LAST NAME:	**FIRST NAME:**	MIDDLE INITIAL:	**DATE OF BIRTH:**
ADDRESS:	CITY:	STATE:	ZIP:
TELEPHONE NUMBER:		GENDER: ☐ MALE ☐ FEMALE	

Insurance Status (Check all that apply): ☐Insured, Vaccines Covered ☐Badger Care
☐Native American or Alaskan Native ☐Insured, Vaccines Not Covered ☐No Health Insurance

School: **Grade/Primary Teacher:**

☐Yes	☐No	Has your child had a serious reaction to a vaccine in the past?
☐Yes	☐No	Does your child have a health problem with their lungs, heart, kidney or a metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?
☐Yes	☐No	Does your child have seizures, a brain or nervous system disorder?
☐Yes	☐No	Does your child have cancer, leukemia, HIV/AIDS, or any other immune system problem?
☐Yes	☐No	Has your child taken any medications that affect their immune system such as steroids, chemotherapy, anti-cancer drugs, or had radiation treatments?
☐Yes	☐No	Has your child received any other immunizations in the past 30 days?
☐ Yes	☐No	Has your child ever had a serious anaphylactic reaction to eggs?

I have been given a copy and have read, or have had explained to me, information about the disease and vaccine to be received. I have had a chance to ask questions which were answered to my satisfaction of my child's school nurse or a public health nurse. I understand the benefits and risks of the vaccine requested and ask that the above checked vaccine be given to my child, as named, for whom I am authorized to make this request. Through my signature below, I am providing consent for my child to receive the vaccination checked above.

X _____ _____
SIGNATURE ***DATE***

Please sign and return to the school Health Office by Friday, October 9.