FOND DU LAC COUNTY HEALTH DEPARTMENT
160 S MACY ST, FOND DU LAC WI, 54935
(920)929-3085

School Influenza Clinic Consent Form

Public Health
Fond du Lac County Health Department

FOR 4 K THROUGH 12th GRADE
Authorization to Receive 2019-2020
Inactivated influenza Vaccine (Injectable)

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 2019-2020 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 to the person named above for whom I am authorized to make this request by the Fond du Lac County Health Department. **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 Fond du Lac County Health Department @ (920)929-3085.

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- Parental Signature on behalf of patient: X ***MUST Use Ink***	Date Signed:

NOTES: For School/Health Department staff:

DOSE #1 Date: _____ ***IM: RD LD RV LV***

Manufacturer_____ Lot #_____

SIGNATURE: _____,RN

DOSE #2 Date: _____ ***IM: RD LD RV LV***

Manufacturer_____Lot #_____

SIGNATURE: _____,RN