

FOR 4 K THROUGH 12th GRADE
Authorization to Receive 2020-2021
Inactivated influenza Vaccine (Injectable)

FOR OFFICE USE ONLY: WIR COUNT

Information collected on this form will be used to document authorization for receipt of the injectable influenza vaccine (flu shot). 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 <input type="checkbox"/> Male <input type="checkbox"/> Female	
City	State	Zip Code	Telephone Number ()	
Race (Check One) <input type="checkbox"/> Native American or Alaska Native <input type="checkbox"/> Other <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Black or African American			Ethnicity (check one) <input type="checkbox"/> Hispanic <input type="checkbox"/> 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 2020-2021 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)?

Other comments from parent/legal guardian:

I have read, or have had explained to me the Vaccine Information Statement (8/5/2019) 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: <div style="text-align: center; font-size: 2em; font-weight: bold; margin-top: 10px;">X</div>	Date Signed:
MUST Use Ink	

NOTES: For Health Department staff:

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

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

Manufacturer GSK Flulaval Lot # 49555

Manufacturer _____ Lot # _____

SIGNATURE: _____,RN

SIGNATURE: _____,RN