VACCINE CONSENT FORM- SCHOOL

Green County Public Health
Prevent. Promote. Protect.

PLEASE PRINT CLEARLY

Name _____ Telephone _____

Address _____ City_____ Zip_____

Date of Birth _____ Age _____ Male _____ Female _____

SCREENING QUESTIONS

1. Are you ill today? Yes _____ No _____
2. Have you ever had a previous reaction to the flu vaccine? Yes _____ No _____
3. Have you ever had a severe reaction/allergy to eggs? Yes _____ No _____
4. Do you have a history of Guillain-Barre syndrome? Yes _____ No _____
   (a type of temporary severe muscle weakness)

If yes answer to any of the above questions, please contact your child's healthcare provider to arrange to receive influenza vaccination in the clinic setting.

I have read or have had explained to me information about the influenza vaccine that I am about to receive. I have had an opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of receiving the vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request.

Signature of person to receive vaccine or person authorized to make the request (parent or guardian), and authorization to release this information to the Wisconsin Immunization Registry.

_____ _____

Recipient/Guardian Signature **Date**

*** For Clinic/Office Use ***

Vaccine	Manufacturer	Lot Number	Injection Site	VIS Given
Influenza			LD RD LV RV	8/15/19

RN Signature _____ Date Administered _____