Door County Public Health 920-746-2234

Consent to Receive Vaccine Form 2019-2020

Complete this form for your child to receive <u>FREE Flu</u> vaccine at school.

Information will be recorded on the Wisconsin Immunization Registry (WIR)

(PLEASE PRINT CLEARLY)

Student's Last Name:	**First Name:**	**Middle:**	**Date of Birth** (mm/dd/yyyy)	**Gender** ☐ Male ☐ Female

Address	**City**	**State**	**Zip Code**

Name of Parent or Guardian Responsible for Student if under 18: (Last, First, M.I.)	**Relationship to Student**

Parent/Guardian Daytime Phone Number(s) ( )	**Name of School**	**School Grade**

Please answer the following questions (circle Yes or No):

Does the child have allergies to medications, food, or a vaccine component, eggs, or latex? **Please list:**	**YES**	**NO**
Has the child ever had a serious reaction to a vaccine in the past?	**YES**	**NO**
Has the child had a health problem with lung, heart, kidney, or metabolic disease (e.g. diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?	**YES**	**NO**
Does the child have a chronic medical condition (asthma, diabetes, heart, lung or kidney diseases)?	**YES**	**NO**
Has the child, a sibling, or a parent had a seizure; has the child had brain, or other nervous system problems?	**YES**	**NO**
Has the child ever had Guillain-Barre Syndrome (a type of temporary severe muscle weakness)?	**YES**	**NO**
Does the child have cancer, leukemia, AIDS, or any other immune system problem?	**YES**	**NO**
In the past 3 months, has the child taken any medications that weaken their immune system such as cortisone, prednisone, other steroids, anticancer drugs, or had radiation treatments?	**YES**	**NO**
Does the child have close contact to someone whose immune system is severely compromised and must be in a protected environment or isolation? (ie, someone who has recently had a bone marrow transplant?)	**YES**	**NO**
In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	**YES**	**NO**
Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	**YES**	**NO**
Has the child received vaccinations in the past 4 weeks? **Please list:**	**YES**	**NO**

Injectable vaccine information https://www.immunize.org/vis/flu_inactive.pdf; flu mist vaccine information https://www.immunize.org/vis/flu_live.pdf

I have read, or have had explained to me, information about the disease(s) and/or 2019-2020 Seasonal Influenza vaccine(s) to be received. 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(s) be given to me or to the person named above for whom I am authorized to make this request. Consent can be revoked by notifying Door County Public Health at 920-746-2234.

By signing below, I am authorizing that my child receive either nasal mist or injectable influenza vaccine:

My preference is: ☐ Seasonal Influenza Injectable vaccine

☐ Seasonal Influenza Flu Mist vaccine (intra-nasal spray)

*We will honor your preference as supply allows

SIGNATURE Person to receive vaccine (18yrs+) or person authorized to sign on the child's behalf	**Date Signed**
X	

<u>FOR OFFICE USE ONLY</u>: Seasonal Flu

Route: IM or IN Site: RD or LD or IN Manufacturer: GSK Medimmune

Lot No: _____

Given by: _____ Date Given: _____