GRADES 6 – 12

School Clinic Consent Form

Authorization To Receive Tetanus, diphtheria, acellular pertussis (Tdap), Influenza, Meningococcal Conjugate (MCV4) and/or Human Papilloma Virus (HPV) Vaccine(s)

Information collected on this form will be used to document authorization for receipt of Tdap and/or influenza, MCV4 and/or HPV vaccine(s) 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. Vaccines will be administered by Fond du Lac County Health Department. (920) 929-3085

My signature below authorizes my child to receive these vaccine(s):
Check all that apply: →

☐ Influenza
☐ Tdap (Tetanus, diphtheria, acellular pertussis) vaccine
☐ MCV4 (Meningococcal conjugate) vaccine
☐ HPV (Human papilloma virus) vaccine (series of 3)

Child's Name :----------PLEASE PRINT CLEARLY----------			*Date of Birth (mm-dd-yyyy)* - -
Last:	First:	Middle:	
Street Address:			Gender ☐ Male ☐Female
City	WI	Zip Code	Telephone Number ( )

Race (Check One)			Ethnicity (check one)
☐Native American or Alaska Native	☐Other	☐Native Hawaiian or Other Pacific Islander	☐Hispanic
☐Asian	☐White	☐Black or African American	☐Non-Hispanic

Mother's Maiden Name (Last, First)	Name of School:	Grade:
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 2014-2015 influenza vaccine and which vaccine is the best for your child. (Injectable vs. Intranasal FluMist)

☐ Yes ☐ No Does your child have a nasal condition serious enough to make breathing difficult?
☐ 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 Has your child received any vaccinations in the last 4 weeks?
☐ Yes ☐ No Does your child have a chronic medical condition such as asthma, diabetes, heart, lung, or kidney diseases?
☐ Yes ☐ No Does your child have a weakened immune system (being treated for cancer, HIV or taking steroid medication)?
☐ Yes ☐ No Is your child pregnant?
☐ Yes ☐ No Does your child have close contact with a person 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?)

I have read, or have had explained to me the Vaccine Information Statements for the above vaccines. 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 me or to the person named above for whom I am authorized to make this request. 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 - Parent or Guardian of Student receiving vaccine **X**	Date Signed

FOR OFFICE USE

Influenza IM RD or LD MIST
Lot No. _____ VIS date: 8/19/14

Tdap: IM RD or LD
Lot No. _____ VIS date:5/19/13

MCV4: IM RD or LD
Lot No._____ VIS date: 10/14/11

HPV: **#1** IM RD or LD
Lot No. _____ VIS date: 5/17/13

RN:_____ Date vaccine administered: _____

VIS date:5/17/13

HPV #2 IM RD or LD Lot No. _____
RN: _____
Date administered _____

HPV #3 IM RD or LD Lot No. _____
RN: _____
Date administered _____