

VACCINE CONSENT FORM



Public Health
Prevent. Promote. Protect.
**Florence County
Health Department**

CHECK THE VACCINES YOUR CHILD SHOULD RECEIVE

- Tdap HPV Meningitis
 Influenza (shot) Influenza (FluMist nasal)

Student Name (Last, First, Middle initial) please print			Male	Female
Date of Birth	Age	Parent/Guardian Name	Phone	
Address		City	State	Zip Code
Does your child have?	<input type="checkbox"/> Badger Care	<input type="checkbox"/> Insured, Vaccines Covered	<input type="checkbox"/> Native American Heritage	
	<input type="checkbox"/> No Health Insurance	<input type="checkbox"/> Insured, Vaccines Not Covered		
School	Grade			

Please Circle Yes or No

Does the child have any allergies to medications, food, a vaccine component or latex? List:	YES	NO
Has the child 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
If the child to be vaccinated is between the ages of 2 and 5 years, has a healthcare provider told you that your child had wheezing or asthma in the past 12 months? <i>If yes, <u>not eligible for FluMist</u></i>	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
Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	YES	NO
In the past 3 months, has the child taken medications that weaken his/her immune system, such as cortisone, prednisone, other steroids, anticancer drugs or had radiation treatments?	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 person to be vaccinated pregnant or is there a chance that she could become pregnant in the next month?	YES	NO
Has the child received any vaccination during the past 4 weeks? List:	YES	NO

CONSENT FOR VACCINATION: I have read, or have had explained to me, the Vaccine Information Statements for the vaccines listed above (www.immunize.org/vis). 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 selected vaccines, if indicated, be given the person named above for whom I am authorized to make this request. Florence County Health Department will bill Medical Assistance/BadgerCare if the child is covered by those programs. I understand that a record of this immunization may be shared through the Wisconsin Immunization Registry (WIR) and with other health care providers directly involved with the vaccinated person's care. This consent form authorizes the administration of multiple doses of a vaccine, if medically indicated. This consent form will expire after the last vaccination is given in a vaccine series.

Signature X _____ Date _____