

## FLU VACCINE CONSENT FORM

Information collected on this form will be used to document permission for receipt of the influenza vaccine. Record of his/her immunization may be shared through the Wisconsin Immunization Registry (WIR) with other health care providers directly involved with the vaccinated person's care.

### Information on person to receive vaccine

Name (Last, First, Middle Initial) Please Print		Sex	Date of Birth	
Parent/Guardian's Name	County	Telephone Number		
Address	City	State	Zip Code	

**This section must be completed.**

Race (Check One) <input type="checkbox"/> African American <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other				
Ethnicity (Check One) <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino				
Eligibility Status (Check all that apply)				
<input type="checkbox"/> Native American	<input type="checkbox"/> Badger Care	<input type="checkbox"/> Medicaid Eligible	<input type="checkbox"/> No Health Insurance	
<input type="checkbox"/> Insured, Vaccines Covered	<input type="checkbox"/> Insured Vaccines Not Covered			

The questions listed below are for screening purposes only and will help us determine if the person named above can receive the flu vaccine. Please circle Yes or No.

1. Is the person to be vaccinated sick today?	Yes	No
2. Does the person to receive the vaccine have a series allergy to eggs or to a component of the influenza vaccine?	Yes	No
3. Has the person to receive the vaccine ever had a serious reaction or allergic response to past flu vaccinations?	Yes	No
4. Has the person to receive the vaccine ever had Guillain-Barre syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	Yes	No

### CONSENT FOR VACCINATION

I have read, or have had explained to me, the Influenza Vaccine Information Statement. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine requested and ask that the vaccine be given to the person named above for whom I am authorized to make this request.

Signature X \_\_\_\_\_ Date \_\_\_\_\_

**FOR OFFICE USE ONLY**

Route IM	Site RD, RV, LD, LV	Manufacturer SP	Lot Number U5599AC (6-35M)	VIS Date 08/07/2015
IM	RD, RV, LD, LV	SP	(3 & OLDER)	08/07/2015

Vaccine Administrator: \_\_\_\_\_ Date: \_\_\_\_\_