Influenza Vaccine Consent Form - Flu Shot

2024-2025 MASS CLINIC - FORM A

PLEASE COMPLETE THE INFORMATION BELOW (PLEASE PRINT)

Full, Legal Name of Student (*First Name Middle Initial. Last Name)*	**Name of School**
Parent/Guardian Name (*First Name Middle Initial. Last Name)* **Relationship to Student**	**Homeroom Teacher** **Grade**
Street Address **Email Address**	**Birth Date** (month/date/year) **Age** **Sex**
City: **Zip Code**	**Home Phone #** **Cell Phone #**

Demographic Information: (Circle one) White American Indian/Native Alaskan Black Asian Hispanic Other

Was your child vaccinated with the seasonal influenza vaccine after July 1, 2024? YES _____ NO _____

HEALTH QUESTIONS:

1. Do any of the following apply to your child?

- ☐ Has a serious allergy to eggs
- ☐ Has other severe, life-threatening allergies PLEASE LIST: _____
- ☐ Has had an allergic reaction after a previous dose of influenza vaccine
- ☐ Has had Guillain-Barré Syndrome within 6 weeks after a previous dose of influenza vaccine

(If you answer YES to any questions, your child may be able to get the seasonal influenza vaccine, but please call the Health Dept to discuss your options.

IF YOU HAVE ANY HEALTH QUESTIONS, PLEASE CONTACT YOUR CHILD'S HEALTH CARE PROVIDER OR CALL THE CRAWFORD COUNTY HEALTH DEPARTMENT TO SPEAK WITH A NURSE AT; 608-326-0229

DO NOT RETURN this form if you do not want your child to receive the Flu Shot at school.

☐ **YES, I Want To Protect My Child, Family And Community From Flu By Allowing My Child To Receive The Flu Shot!**

I have received, read, and understand the CDC Vaccine Information Statement for the seasonal influenza vaccine and understand the risk and benefits of the Flu vaccine. I give permission to the Crawford County Health Department to give my child the vaccine in my absence, and for data entry, billing and storage according to Wisconsin Department of Health policies, to assure optimal healthcare for my child.

_____ _____

Signature of Parent/Guardian Date

AREA FOR OFFICIAL USE ONLY FOR ADMINISTRATION

Are you experiencing any fever or upper respiratory infection? YES NO UNKNOWN

MedImmune (MED) **Flu, IM (NAS), 0.2ml** **VIS: 08/6/2021** Vaccine Lot # & Expiration Date Label	Nurse/clinic notes;

Notes:

Route:	Site of Injection:	RN Signature:	Date Given:
IM	LV RV Left Del Right Del	Lisa Kennicker, RN Tricia Koeller, RN	