Influenza Vaccine Consent Form - Flu Shot

2025-2026 MASS CLINIC - FORM B **6th – 12th Grade Students ONLY**

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**	**Grade**
Street Address **Email Address**	**Birth Date** (month/date/year) **Age** **Sex**
City: **Zip Code**	**Phone #**

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

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 NOT be able to get the seasonal influenza vaccine, but please call the Health Dept at 608-326-0229 to discuss your options or contact your child's healthcare provider)

☐ YES, I have read and answered the questions on this form accurately and understand that incorrect information could cause serious risks to myself or the person named above. I have received and read the Vaccine Information Sheet provided and have had the opportunity to ask questions that were answered to my satisfaction and do wish to receive the flu vaccination fully understanding the risks and benefits. I understand this information will be entered into the WI Immunization Registry for Public Health purposes. I release CCHHS, employees, and agents harmless from any and all liability arising in relation to this consent.

My signature below indicates my permission for the flu vaccine or Flumist to be given to me or to the person named above, and I am the parent or legal authority with authority to consent to vaccination.

_____ _____

Signature of Parent/Guardian Date

AREA FOR OFFICIAL USE ONLY FOR ADMINISTRATION

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

MedImmune (MED) **Flu, IM (NAS), 0.2ml** **VIS: 08/6/2021**	Vaccine Lot # & Expiration Date Label	Nurse/clinic notes;
Notes:		
Route: IM	Site of Injection: LV RV Left Del Right Del	RN Signature: Lisa Kennicker, RN Tricia Koeller, RN
Date Given:		

WIR _____