FOR OFFICE USE	
VFC-Nasal	VFC-IM
Private-Nasal	Private-IM

2014 Influenza Vaccine School Consent Form

Barron County Public Health

STUDENT'S NAME (Last)	(First)	(M.I.)	**GRADE**	**TEACHER**	
PARENT/LEGAL GUARDIAN'S NAME (Last)	(First)	(M.I.)	**STUDENT'S BIRTH DATE (m/d/y)** / /	**AGE**	**GENDER** M / F
ADDRESS			**PARENT/GUARDIAN DAYTIME PHONE NUMBER:**		
CITY	**STATE**	**ZIP**	**SCHOOL**		

Please answer the following questions by circling "YES" or "NO". We need this important health information to determine if your child should receive this vaccine.		
1. Does your child have a serious allergy to eggs?	YES	NO
2. Does your child have any other serious allergies? Please list: ____	YES	NO
3. Has your child ever had a serious reaction to a previous dose of flu vaccine?	YES	NO
4. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	YES	NO

There are two kinds of 2014-2015 influenza vaccine. Your answers to the following questions will help us know which of the two kinds of vaccine your child can get. (Please circle "YES" or "NO")		
1. Has your child been vaccinated with any vaccine (not just flu) within the past 30 days? If yes, please indicate type and date. Vaccine: _______________________________________ Date given: month______day_______year___________	YES	NO
2. Does your child have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood? Please list: ____	YES	NO
3. Is your child on long-term aspirin or aspirin-containing therapy (for example, does your child take aspirin every day)?	YES	NO
4. Does your child have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)?	YES	NO
5. Is your child pregnant?	YES	NO
6. Does your child have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?	YES	NO
7. Did your child receive influenza vaccine last year? If yes, circle how many doses your child received? Doses 1 2	YES	NO
8. Do you prefer your child get one type of vaccine over another? If "YES" check which kind of vaccine below that you want your child to receive. **Your child may not receive this preferred vaccine if he/she has a medical contraindication or if that vaccine is unavailable.** _______ Flu Mist (intranasal) _________Injectable (Intramuscular)	YES	NO

Please circle "YES" or "NO" for each consent item, complete insurance information and sign below. Your child will not receive influenza vaccination without a parent or guardian signature.		
1. I have read the 2014-15 Vaccine Information Statement for the influenza vaccine and understand the risks and benefits. This consent allows for the Barron County Public Health to administer influenza vaccine to the child listed above.	YES	NO
2. I consent to sharing influenza immunization data with the Wisconsin Immunization Registry (WIR) so that my clinic/physician is aware that my child received this vaccine.	YES	NO
3. Please circle the best description of your child's health insurance coverage: **Badger Care** **Health Insurance, vaccines covered** **Health Insurance, vaccines not covered** **No health insurance**		

Parent or Guardian Signature: ____ **Date**: ______________

Date Dose Administered	Route	IM Site	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator
	☐ IM ☐ Intranasal	☐ LD ☐ RD			