Do Not Complete This Form If You Do Not Want Your Child ***to Receive The Influenza Vaccine***

2024 Influenza Vaccine School Consent Form

Barron County DHHS Public Health

STUDENT'S NAME (Last)	(First)	(M.I.)	**GRADE**	**TEACHER**	
PARENT/LEGAL GUARDIAN'S NAME (Last)	(First)	(M.I.)	**STUDENT'S BIRTH DATE (mm/dd/yyyy)** / /	**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.

Does your child have a serious allergy to eggs?	YES	NO
Does your child have any other serious allergies? Please list: _____	YES	NO
Has your child ever had a serious reaction to a previous dose of flu vaccine?	YES	NO
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
Has your child been vaccinated with any vaccine within the past 30 days? If yes, please indicate type and date. Vaccine: _____ Date given: month_____day_____year_____	YES	NO
Has your child been vaccinated for influenza this year? Date given: month_____day_____year_____	YES	NO
Did your child receive influenza vaccine last year? If yes, circle how many doses your child received? Doses 1 2	YES	NO
I have read the Vaccine Information Statement for the influenza vaccine and understand the risks and benefits.	YES	NO

Your child's vaccination record, including those provided at/to School(s) will be shared with the Wisconsin Immunization Registry (WIR) and Wisconsin Immunization Providers for the purpose of maintaining a complete and accurate record to assist in assuring full immunization**. Please contact Public Health at 715-537-5691 ext 6442, prior to the date your child will be vaccinated if you do not wish to have your child's immunization record shared.**

Please check the best description of your child's health insurance coverage:

- ☐ **Badger Care**
- ☐ **Health Insurance, vaccines covered**
- ☐ **Health Insurance, vaccines not covered**
- ☐ **No Health Insurance**

Your child will not receive the influenza vaccination without a parent or guardian signature.

Signing this consent al**lows Barron County Public Health to administer influenza vaccine to the child listed above:**

Parent or Guardian Signature: _____ Date: _____

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