Iowa County Health Department

Return this form only if your child will be receiving the Flu Shot at school.

Information collected on this form will be used to document permission for your child to receive the seasonal influenza (flu) vaccine at your child's school. Record of this immunization may be shared through the Wisconsin Immunization Registry (WIR) with other health care providers directly involved with your child's care.

SCHOOL: _____

Student's Name (Last, First, Middle initial)			**Gender** ☐ **Male** ☐ **Female**
Student's Birthdate Month _____ Day _____ Year _____	**Student's Age**	**School Grade**	**Parent/Guardian Daytime Phone Number** ( )
Home Address	**P.O. Box**	**City**	**County** **State** **Zip Code**
		Registry (WIR) ?	☐ **YES** ☐ **NO**

Please answer the following questions (circle Yes or No):

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 or allergic response to past flu vaccinations?	YES	NO
4. Has your child ever had Guillian Barré syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	YES	NO

If you answered YES to any of the above questions, please contact your doctor for the flu vaccination.

CONSENT FOR CHILD'S VACCINATION:

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

Parent/Guardian Signature: _____ **Date:** _____

FOR OFFICE USE **VIS date: 08/15/2019**

Route = IM **Body site (circle one) = RD or LD / RV or LV**

Manufacturer: GSK FluLaval Quadrivalent **Lot No. 95RZ3** **Date vaccine administered:** _____

Signature and title of person administering vaccine: _____