2017 – 2018 INFLUENZA VACCINE CONSENT FORM

Information collected on this form will be used to document permission for your child to receive the 2017-2018 seasonal influenza 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	**Student's Age**	**School Grade**	**Parent/Guardian Daytime Phone Number**
Home Address	**P.O. Box**	**City**	**County** **State** **Zip Code**
Parent/Guardian's Name		**Okay to share the seasonal influenza immunization data with the Wisconsin Immunization 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 Barre' syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	Yes	No

CONSENT FOR CHILD'S VACCINATION:

I have read, or have had explained to me, the Vaccine Information Statement (VIS) for the 2017-2018 seasonal influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine requested and ask that the vaccine be given to the student named above for whom I am authorized to make this request.

Signature X_____ **Date:** _____

FOR OFFICE USE VIS Date: 8/7/15

Mass Influenza School Clinic

2017-2018 Seasonal Flu: Route = IM Body site (circle one) = RD or LD Dose: 1 or 2

Manufacturer: **FLUARIX QUADRIVALENT P-FREE/GSK** Lot No: **TL54R**

Signature and title of person administering vaccine: _____

Date vaccine administered: _____