Door County Public Health Department – 421 Nebraska Street, Sturgeon Bay, WI 54235 – 920-746-2234

Consent To Receive Vaccine(s) Form

Information collected on this form will be used to document consent to receive **FREE** vaccine at your child's school. Information may be shared through the Wisconsin Immunization Registry (WIR) with other health care providers directly involved with the student.

Information on person to receive FREE vaccine (PLEASE PRINT CLEARLY IN BLACK INK)

Student's Name:			Date of Birth (mm/dd/yyyy)
Mailing Address	City	State	Zip Code
Gender ☐ Male ☐ Female	Race (Check one) ☐ African American ☐ American Indian or Alaskan Native ☐ Asian ☐ Native Hawaiian/Pacific ☐ White ☐ Other	Ethnicity (Check one) ☐ Hispanic or Latino ☐ Non-Hispanic or Latino	Mother's Maiden Name (Last, First, M.I.)
Name of Parent or Guardian Responsible for Student if under 18: (Last, First, M.I.)		Relationship to Student	
Parent/Guardian Daytime Phone Number(s) ( )	Name of School		School Grade

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

Is the child sick the day of vaccinations? (If the child is well enough to attend school, he/she will be vaccinated.)	YES	NO
Does the child have allergies to medications, food, a vaccine component, or latex? **Please list:**	YES	NO
Has the child ever had a serious reaction to a vaccine in the past?	YES	NO
Has the child, a sibling, or a parent had a seizure; has the child had brain, or other nervous system problems?	YES	NO
Has the child ever had Guillain-Barre Syndrome?	YES	NO
Has the child received vaccinations in the past 4 weeks? **Please list:**	YES	NO

I have been given a copy and have read, or have had explained to me, information about the disease and the Seasonal Influenza vaccine to be received. 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 person named above for whom I am authorized to make this request. Consent can be revoked by notifying the Door County Public Health Department at 920-746-2234.

I give permission to share my child's immunization records including those provided to school(s) with the Wisconsin Immunization Registry and my Immunization Provider for the purpose of maintaining a complete and accurate record to assist in assuring full immunization. Check here if you do **NOT** give your permission to share: ☐

By signing below I give consent for my child to receive the following vaccine(s): (Check all that apply)

☐ **Seasonal Influenza** (Only injectable vaccine will be offered)

SIGNATURE – Person to receive vaccine (18yrs and over) or person authorized to sign on the child's behalf X	Date Signed

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