



### Consent to Receive Influenza (Flu) Vaccination

**Important:** Answer the three questions below, fill out ALL information, and sign the form.

*Return to the Main Office at School 2 weeks prior to clinic.*

I give permission for the patient listed below to receive a Flu (Influenza) Shot

- \*Does the patient below have allergies to a vaccine component or to latex?  Yes  No
- \*Has the patient below had a serious reaction to a vaccine in the past?  Yes  No
- \*Has the patient below had brain or other nervous system problems?  Yes  No

Patient's Name (Last, First, Middle Initial)		Mother's Maiden Name (Last, First, Middle Initial)			
Address		City	County	State	Zip Code
Main Phone ( )	Alternate Phone ( )	Date of Birth	Age	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Race <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific <input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Other		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino			
Name of School Attending		Grade	Name of Physician		
Name of Parent/Guardian Responsible for Patient (Last, First, MI)			Relationship to Patient		

I have been given a copy and have read, or have had explained to me, information about the disease and 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 above whom I am authorized to make this request. I give permission to share the patient'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 ONLY if you do NOT give your permission to share with the Wisconsin Immunization Registry.**

SIGNATURE – (Parent or Guardian if for a child under 18 years) X	Date
---	------

<b>FOR OFFICE USE - Please list Insurance information here if an adult vaccination:</b>				
Medicare # _____				
<b>Medicare Advantage Plan:</b>				
Medica Advantage Plan # _____				
Humana Advantage Plan # _____				
Security Advantage Plan # _____				
Amount Billed: \$45.00		Cash or Check (circle one) Amount paid \$ _____		
Clinic Site (circle one): Delong Northstar South FallCreek Augusta Altoona HS Altoona Elem Sports Center ECCHD				
Signature and Title of person administering vaccine:				Date
Vaccine	Route	Site	Dose	Mfr/Lot No.
Influenza	IM	RV LV RD LD	1 2	GSK/