WIR_____
_____
_____

Crawford County Public Health 2016-17

SCHOOL

_____

Teachers Name and Grade

DEPARTMENT OF HEALTH SERVICES
Division of Public Health F-*00048 (3/09)*

STATE OF WISCONSIN
Wis. Stats. 252.04

***Authorization to receive Tetanus, diphtheria, acellular pertussis (Tdap), Meningococcal Conjugate (MCV4)* and/or *Human Papilloma Virus (HPV)* Vaccine(s).**

Information collected on this form will be used to document authorization for receipt of Tdap, MCV4 and/or HPV vaccine (s) at your child's school. Information may be shared through the Wisconsin Immunization Registry (WIR) with other health care providers directly involved with your child to assure completion of the vaccine schedule.

My signature below authorizes my child to receive these vaccine(s)
Check all that apply: →

- ☐ **Tdap** (Tetanus, diphtheria, acellular pertussis) vaccine [**Required** (1 dose)]
- ☐ **MCV4** (Meningococcal conjugate) vaccine [**Recommended** (2 dose)]
- ☐ **HPV** (Human papilloma virus) vaccine (**Recommended** (3 doses)]

Patient's Name (Last, First, Middle Initial) Email

Mother's Maiden Name (Last, First)

Address P. O. Box City County State Zip Code

Home Telephone Number
( )

Date of Birth (mm/dd/yyyy)

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

Name of Parent or Guardian Responsible for Patient (Last, First, Middle Initial) Relationship to Patient

I have been given a copy and have read, or have had explained to me, information about the disease(s) and vaccine(s) 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(s) requested and ask that the vaccine(s) be given to me or to the person named above for whom I am authorized to make this request.

☐ Check here if you **DO NOT** give your 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.

Signature – Person authorized to sign on patient's behalf. Date

X

For Office Use

Tdap route= IM site RD or LD Manufacturer, Lot #_____ _____
VIS date 2/24/2015 Gloria Wall, RN Michelle Breuer, RN Judy Powell, RN Lisa Cummer, RN Karen Reilly RN Date Admin & VIS Given

MCV4: route= IM site RD or LD Manufacturer, Lot #_____ _____
VIS date: 10/14/2011 Gloria Wall, RN Michelle Breuer, RN Judy Powell, RN Lisa Cummer, RN Karen Reilly RN Date Admin & VIS Given

HPV #1 route= IM site RD or LD Manufacturer, Lot #_____ _____
VIS date: 05/17/2013 Gloria Wall, RN Michelle Breuer, RN Judy Powell, RN Lisa Cummer, RN Karen Reilly RN Date Admin & VIS Given

HPV #2 route= IM site RD or LD Manufacturer, Lot #_____ _____
VIS date: 05/17/2013 Gloria Wall, RN Michelle Breuer, RN Judy Powell, RN Lisa Cummer, RN Karen Reilly RN Date Admin & VIS Given

HPV #3 route= IM site RD or LD Manufacturer, Lot #_____ _____
VIS date: 05/17/2013 Gloria Wall, RN Michelle Breuer, RN Judy Powell, RN Lisa Cummer, RN Karen Reilly RN Date Admin & VIS Given