WIR_____

Date:_____

Crawford County Public Health 2017-18

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)

Information collected on this form will be used to document authorization for receipt of TdaP 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)	☐ **TdaP** (Tetanus, diphtheria, acellular pertussis) vaccine – **REQUIRED** **WI Student Immunization Law requires all students entering 6th grade receive a dose of the TdaP Vaccine**

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 o r LD Manufacturer, Lot #______________________________ ________________

VIS date 2/24/2015 Gloria Wall, RN Michelle Breuer, RN Judy Powell, RN Lisa Cummer, RN Ashley Burns RN Date Admin & VIS Given