2017-18

Crawford County Health Department Influenza Administration Record

WIR _____
_____

The doctor or clinic may keep this record in your medical file or your child's medical file. They will record what vaccine was given, when the vaccine was given, the name of the company that made the vaccine, the vaccine's special lot number, the signature and title of the person who gave the vaccine, and the address where the vaccine was given.

I have read or have had explained to me the information about influenza and influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me or the person named below from whom I am authorized to make this request. School influenza vaccination dates late September/early October.

PLEASE PRINT

1. SCHOOL	2. TEACHER	3. GRADE

Patient's given name:

_____
FIRST **MI** **LAST**

E-MAIL ADDRESS: _____

Age:

Patients DOB:

/ /

Street address:

Sex

M ☐ F☐

City	State WI
Zip code	Telephone / Cell ( )

MOTHER'S MAIDEN NAME

_____

Have you ever had a severe reaction to the influenza vaccine? Yes No Unk Are you or could you be pregnant? Yes No

Are you allergic to eggs, thimerosal or latex? Yes No Unk Have you ever had Guillian Barre Syndrome? Yes No Unk

☐ Check here if you **DO NOT** 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.

*****Depending on whether your child received an influenza vaccine in the past, some children younger than nine years of age will need 2 doses of vaccine 4 weeks apart that will be included with this consent. *****

Signature of person authorized to sign on patient's behalf.

Signature	Date: **2017-18**

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SCHOOL	**MASS CLINIC EXERCISE**	**DATE**

ARE YOU EXPERIENCING ANY FEVER OR UPPER RESPIRATORY INFECTION? Yes No Unk

				Manufacturer, Lot #

Route = IM VIS Date: 08/15/2015 Site of Injection: **Left Del. Right Del. Date of Admin. & VIS given_____**

RN Signature/Credentials: Gloria Wall RN Michelle Breuer RN Judy Powell RN Lisa Cummer RN Ashley Burns RN