ADOLESCENT VACCINE CONSENT FORM

Public Health
Prevent. Promote. Protect.
Florence County
Health Department

PLEASE MARK THE VACCINES YOUR CHILD SHOULD RECEIVE if eligible:

- ☐ **HPV (Series of 2 or 3 shots (depends on age) given over the school year)**
- ☐ **Tdap** ☐ **Influenza**
- ☐ **Meningitis (1st shot at 11 yrs and booster at 16 yrs)**

Student Name (Last, First, Middle initial) please print			Male Female
Date of Birth	Age	Parent/Guardian Name	Telephone Number ( )
Address	City	County State	Zip Code
Does your child have? ☐ Badger Care ☐ No Health Insurance	☐ Insured, Vaccines Covered ☐ Insured, Vaccines Not Covered	☐ Native American Heritage	
School	Grade		

Please Circle Yes or No

Does the child have any **allergies** to medications, food, a vaccine component or latex? List:_____	YES	NO
Has the child had a serious reaction to a vaccine in the past?	YES	NO
Has the child had a health problem with **lung**, **heart**, **kidney**, or metabolic disease (e.g. diabetes), asthma or a Is he/she on long-term aspirin therapy?	YES	NO
Has the child, a sibling, or a parent had a **seizure?**	YES	NO
Has the child had **brain** or other **nervous system** problems?	YES	NO
Does the child have **cancer**, **leukemia**, **HIV/AIDS**, or any other immune system problem?	YES	NO
In the past 3 months, has the child taken medications that weaken his/her immune system, such as **cortisone**, **prednisone**, other **steroids**, **anticancer drugs** or had **radiation** or **chemo-therapy** treatments?	YES	NO
In the past year, has the child received a **transfusion of blood or blood products**, or been **given immune (gamma) globulin** or an **antiviral drug**?	YES	NO
Is the person to be vaccinated **pregnant** or is there a chance she could become pregnant in the next month?	YES	NO
Has the child received any vaccination during the past 4 weeks? List: _____	YES	NO

CONSENT FOR VACCINATION: I have read, or have had explained to me, the Vaccine Information Statements for the vaccines listed above (www.immunize.org/vis). 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 selected vaccines, if indicated, be given the person named above for whom I am authorized to make this request. Florence County Health Department will bill Medical Assistance/BadgerCare if the child is covered by those programs. I understand that a record of this immunization may be shared through the Wisconsin Immunization Registry (WIR) and with other health care providers directly involved with the vaccinated person's care. **This consent form authorizes the administration of multiple doses of a vaccine, if medically indicated. This consent form will expire after the last vaccination is given in a vaccine series (for example the HPV or Meningococcal series require more than one dose).**

Signature X_____ **Date** _____

Updated March 2017

FOR OFFICE USE:

Is the child well today? YES NO

MENINGOCOCCAL
VIS DATE: 3/31/2016

Route IM Body site RD RV LD LV Dose 1 2

Manufacturer _____Lot No:_____

HPV
VIS DATE: 12/02/2016

Route IM Body site RD RV LD LV Dose 1 2 3

Manufacturer _____Lot No:_____

TDAP
VIS DATE: 2/24/2015

Route IM Body site RD RV LD LV Dose 1

Manufacturer_____ Lot No:_____

INFLUENZA
VIS DATE: 8/7/2015

Route IM Body site RD RV LD LV Dose 1 2

Manufacturer_____ Lot No:_____

Signature/Title of person administering vaccine _____

Date vaccine administered_____