LA CROSSE COUNTY HEALTH DEPARTMENT

Authorization to receive Seasonal Influenza (injection or flu mist) Vaccination

Information collected on this form will be used to document authorization for receipt of seasonal influenza vaccine 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 this vaccine: Check one: →	☐ Influenza-inactivated, injection ☐ Influenza-live, intranasal mist

Patient's Name (Last, First, Middle Initial)	Mother's Maiden Name (Last, First, Middle Initial)

Address	City	County	State	Zip Code

Home Telephone Number ( )	Date of Birth (mm/dd/yyyy)	Gender ☐ Male ☐ Female

Race (Check one)
☐ African America ☐ American Indian or Alaskan Native
☐ Asian ☐ Native Hawaiian/Pacific
☐ White ☐ Other

Ethnicity
☐ Hispanic or Latino
☐ Non-Hispanic or Latino

Eligibility Status – This section must be completed (check all that apply).
☐ Native American ☐ BadgerCare Plus ☐ Insured, Vaccines Covered
☐ Medicaid Eligible ☐ No Health Insurance ☐ Insured, Vaccine Not Covered

Name of Physician	Name of School	Grade

Name of Parent/Guardian Responsible for Patient (Last, First, M.I.)	Relationship to Patient

Okay to share immunization data with the Wisconsin Immunization Registry (WIR)?
☐ Yes ☐ No

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.

Wisconsin Medicaid restricts billing recipients for any covered service(s). I understand that if the above named is a Medicaid/BadgerCare recipient I cannot be charged an administration fee or asked for any type of donation for the administration of any vaccine that is being provided.

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

FOR OFFICE USE
Influenza = IN or IM (circle one) If IM – RD or LD dose (circle one) – 1 or 2
Manufacturer ________________________________ Lot No. ________________________ VIS date: 07/26/2013

Signature and Title of person administering vaccine: ________________________________ Date: _________________
LHD Clinic Site: ____

LA CROSSE COUNTY HEALTH DEPARTMENT

Screening Checklist for Contraindications to Vaccination:

For parents/guardians: The following questions will help us to determine if there is any reason we should not give your child a flu vaccination today. If you answer “yes” to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions might need to be asked.

1. Is the person to be vaccinated sick today? ☐ Yes ☐ No

2. Does the person to be vaccinated have allergies to medications, eggs, any component of vaccines they have had in the past, or latex? ☐ Yes ☐ No

3. Has the person to be vaccinated ever had a serious reaction to a vaccine (flu or Dtap) in the past?
☐ Yes ☐ No

4. Has the person to be vaccinated ever had Guillain-Barré syndrome? ☐ Yes ☐ No

5. Does the person to be vaccinated have a long-term health problem with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., diabetes), or anemia or another blood disorder? ☐ Yes ☐ No

6. Is the person to be vaccinated younger than age 2 years or older than age 49 years? ☐ Yes ☐ No

7. If the person to be vaccinated is a child age 2 through 4 years, in the past 12 months, has a healthcare provider told you the child had wheezing or asthma? ☐ Yes ☐ No

8. Does the person to be vaccinated have cancer, leukemia, HIV/AIDS, or any other immune system problem; or, in the past 3 months, have they taken medications that weaken the immune system, such as cortisone, prednisone, other steroids, or anticancer drugs; or have they had radiation treatments? ☐ Yes ☐ No

9. Is the person to be vaccinated receiving antiviral medications? ☐ Yes ☐ No

10. Is the child or teen to be vaccinated receiving aspirin therapy or aspirin-containing therapy? ☐ Yes ☐ No

11. Is the person to be vaccinated pregnant or could she become pregnant within the next month?
☐ Yes ☐ No

12. Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g., an isolation room of a bone marrow transplant unit)? ☐ Yes ☐ No

13. Has the person to be vaccinated received any other vaccinations in the past 4 weeks? ☐ Yes ☐ No

14. Has the person to be vaccinated had a seizure or any brain or other nervous system problems?
☐ Yes ☐ No

15. Has the person to be vaccinated received a transfusion of blood or blood products, or been given (gamma) globulin in the past six months? ☐ Yes ☐ No

Form completed by: ____Date:___________________________

Form reviewed by: ____ Date:____________________