

Manitowoc County Public Health Department
 1028 South 9th Street
 Manitowoc, WI 54220
 920-683-4155

INFLUENZA VACCINE CONSENT FORM

Information collected on this form will be used to document authorization for receipt of influenza vaccine. 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.

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

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

Address

PO Box

City

County

State

Zip Code

Telephone Number

Date of Birth (mm/dd/yyyy)

Gender

Male

Female

Race (Check One)

Ethnicity (Check One)

<input type="checkbox"/> African American	<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Hispanic or Latino
<input type="checkbox"/> Native Hawaiian/Pacific	<input type="checkbox"/> White	<input type="checkbox"/> Other	<input type="checkbox"/> Non-Hispanic or Latino

Eligibility Status – This section must be completed. (Check all that apply)

<input type="checkbox"/> Native American	<input type="checkbox"/> Badger Care	<input type="checkbox"/> Insured, Vaccines Covered
<input type="checkbox"/> Medicaid Eligible	<input type="checkbox"/> No Health Insurance	<input type="checkbox"/> Insured, Vaccines NOT Covered

Name of Physician/Clinic

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

Relationship to Patient

Okay to share immunization date with Wisconsin Immunization Registry? (WIR)

Yes

No

I have 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 vaccines(s) be given to me or to the person named above for whom I am authorized to make this request.

Wisconsin Medicaid restricts billing recipients for any covered service(s). I understand that if I am 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 to receive vaccine or person authorized to sign on the patient's behalf.

DATE SIGNED:

X

10/27/2020

FOR OFFICE USE ONLY

Influenza Route= IM

Site= (circle one) RD LD RV LV

Lot No. = (circle one) 494S5 2SM24

Manufacturer: GSK

Signature & Title – Person Administering Vaccine: _____

Date Vaccine Administered: 10/27/2020

10/01/2020

Screening Checklist for Contraindications to Inactivated Injectable Influenza Vaccination

PATIENT NAME _____

DATE OF BIRTH _____ / _____ / _____
month day year

For patients (both children and adults) to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child inactivated injectable influenza vaccination today. If you answer “yes” to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Is the person to be vaccinated sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the person to be vaccinated have an allergy to a component of the vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the person to be vaccinated ever had Guillain-Barré syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____