Consent and Administration Record – *Health Department's* School-Based Immunization Clinic

Health Department Address: 428 Underwood Ave Montello, Wi 53949

Name of my child's school: ________________________ Grade: ____________ Classroom/Teacher:________________

<table>
<tr><td colspan="8">Information about the student receiving vaccine(s) – please print</td></tr>
<tr><td colspan="3">Child's last name</td><td colspan="3">First name</td><td colspan="2">MI</td></tr>
<tr><td colspan="4">Street Address</td><td>City</td><td colspan="2">State
WI</td><td>Zip</td></tr>
<tr><td>Date of Birth</td><td>Age</td><td colspan="2">Gender
☐ Male
☐ Female</td><td colspan="4">Mother's maiden name</td></tr>
<tr><td colspan="6">Race (check all that apply)
☐ Asian ☐ Native American/Alaskan Native ☐ White
☐ Black/African America ☐ Native Hawaiian/Pacific Islander ☐ Other __________</td><td colspan="2">Ethnicity
☐ Hispanic/Latino
☐ Non-Hispanic/Latino</td></tr>
<tr><td colspan="3">Parent / legal guardian Last name</td><td colspan="3">First name</td><td colspan="2">Phone number (where you can be reached on date of clinic)</td></tr>
</table>

I give consent for my child to receive the following vaccines:

☐ **HPV** ☐ **Hep B**

☐ **Tdap**

☐ **Meningococcal**

☐ **Varicella**

☐ I do not want my child to receive <u>any</u> immunizations.

	Questions about the student receiving vaccine(s)	Yes	No
1	Has your child had a serious reaction to a vaccine in the past?		
2	Does your child have a health problem with their lungs, heart, kidney or a metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?		
3	Does your child have seizures, a brain or nervous system disorder?		
4	Does your child have cancer, leukemia, HIV/AIDS, or any other immune system problem?		
5	Has your child taken any medications that affect their immune system such as steroids, chemotherapy, anti-cancer drugs, or had radiation treatments?		
6	Has your child received any other immunizations in the past 30 days?		
7	Is your child pregnant or planning to become pregnant in the next month?		

____ ____________________

Signature of Parent/Legal Guardian — Date Signed

____ ____________________

Printed name of Parent/Legal Guardian — Relationship to child

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Vaccine	Route	Site	Lot Number	Manufacturer	Signature & Title – person administering vaccine	VIS date
HPV	IM / SC	LD RD				8/6/21
Tdap	IM / SC	LD RD				8/6/21
MMR	IM / SC	LD RD				8/6/21
Varicella	IM / SC	LD RD				8/6/21
Hep B	IM / SC	LD RD				5/12/23
Meningococcal	IM / SC	LD RD				8/6/21
vaccine	IM / SC	LD RD				MM/DD/YYYY
vaccine	IM / SC	LD RD				MM/DD/YYYY
vaccine	IM / SC	LD RD				MM/DD/YYYY
vaccine	IM / SC	LD RD				MM/DD/YYYY

Comments:

Date VISs provided to parent/guardian: