

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: _____

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

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 any immunizations.

I would like my child to receive their vaccines:

- During the school day, without a parent or guardian present.
- After school so I can be there.

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: