2026 VACCINE CONSENT AND ADMINISTRATION FORM
Chippewa County Department of Public Health School-Based Clinic

SCHOOL

Student Name (Last, First, Middle Initial) Please print			Sex Assigned at Birth (Check one) Male ☐ Female ☐ Intersex ☐
Date of Birth	Age	Parent/Guardian Name	Telephone Number
Address	City	State	Zip Code
Does your child have? ☐ Insured, Vaccines Covered ☐ Native American Heritage ☐ No Health Insurance ☐ Insured, Vaccines Not Covered ☐ MA/Badger Care			
Race (Check all that apply) ☐Asian ☐Native American/Alaskan Native ☐White ☐Black/African American ☐Native Hawaiian/Pacific Islander ☐Other _____			Ethnicity ☐Hispanic/Latino ☐Non-Hispanic/Latino
School	Teacher		Grade

	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 or 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?	☐	☐

I give consent for my child to receive (Check ONLY ONE):

☐ **FluMist**

☐ **Influenza (Flu shot)***Reserved for those with asthma, underlying medical conditions, on an aspirin regimen, live/care for someone who is immunosuppressed, or per parent request.**

Please share any ways we can support your child and make this a good vaccination experience.

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CONSENT FOR VACCINATION: I have read, or have had explained to me, the Vaccine Information Statement for the vaccine Influenza. 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 vaccine(s) be given to the person named above for whom I am authorized to make this request. I understand that a record of this immunization may be shared through the Wisconsin Immunization Registry (WIR) and with other healthcare 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.

Signature X_____ **Date** _____

FOR OFFICE USE:

Is child well today? Y N *Route:* Nasal / IM *IM site:* RD LD Lot #_____ EXP _____

Vaccine Administrator Initials _____ Date: _____