Authorization to Receive the following Vaccines: **Grant County Health Department 2026-2027**

Influenza vaccine
MMR (measles, mumps, and rubella)

Information collected on this form will be used to document authorization for receipt of Influenza and MMR vaccine(s) 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 these vaccine(s): →
Check all that apply:

- ☐ Influenza vaccine [**Recommended** seasonally (1 dose)]
- ☐ MMR vaccine (2-dose series 4 weeks apart)

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

Address	P. O. Box	City	County	State	Zip Code

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

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

Ethnicity (Check one)
☐ Hispanic or Latino
☐ Non-Hispanic or Latino

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

☐ **Native American** ☐ **Badger Care** ☐ **Insured, Vaccines Covered**
☐ **Medicaid Eligible** ☐ **No Health Insurance** ☐ **Insured, Vaccines Not Covered**

Name of Physician	Name of School	Grade/Teacher

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

Okay to share immunization data with 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(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 vaccine(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. **X**	Date Signed

FOR OFFICE USE:

☐ **MMR** (Right Arm)

LOT:
EXP:
VIS: 01/31/2025

☐ **Influenza** (Left Arm)
Preservative Free
Lot: NM922
Exp: 06/30/2027
VIS: 01/31/2025

Signature and title of person administering vaccine:_____ Date vaccine administered: _____