

### Vaccine Administration Record and Screening

Information collected on this form will be used to document authorization for receipt of vaccines. The information will be shared through the Wisconsin Immunization Registry (WIR) with other health care providers directly involved with the patient to assure completion of the vaccine schedule. Information collected on this form is voluntary. Consult with your physician about the risks and benefits of your child receiving this vaccine.

**PLEASE PRINT**

Last name of person receiving vaccine: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_  
 Student's mother's maiden last name: \_\_\_\_\_ First Name: \_\_\_\_\_  
 Gender:  Male  Female Date of birth: month \_\_\_\_ day \_\_\_\_ year \_\_\_\_ Age: \_\_\_\_\_  
 Ethnicity:  Non-Hispanic  Hispanic Race:  Amer Indian  Asian  Black/African Amer  White  Other  
 Parent/Guardian: Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Telephone: \_\_\_\_\_ Street Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

**QUESTIONS BELOW MUST BE ANSWERED**

Questions about the student receiving the vaccine:	PLEASE MARK ONE	
	Yes	No
1. Does the student have any serious allergies to medications, foods (especially eggs), vaccines, thimerosal, or latex?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the student have a history of Guillain-Barré Syndrome? (Temporary paralysis)	<input type="checkbox"/>	<input type="checkbox"/>
3. Did the student receive any immunizations/vaccines in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>
4. Did the student ever have a serious reaction after receiving a vaccination?	<input type="checkbox"/>	<input type="checkbox"/>
<b>There are two kinds of 2009 H1N1 influenza vaccine. Your answers to the following questions will help Public Health know which vaccine your child can get.</b>	<b>PLEASE MARK ONE</b>	
	<b>Yes</b>	<b>No</b>
5. Does your child have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does your child take aspirin or medicine that contains aspirin every day?	<input type="checkbox"/>	<input type="checkbox"/>
7. Does your child have a weak immune system (from HIV, cancer, or medications such as steroids or those used to treat cancer)?	<input type="checkbox"/>	<input type="checkbox"/>
8. Is your child pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
9. Does your child have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?	<input type="checkbox"/>	<input type="checkbox"/>

**Consent for child's vaccination (must be signed or child cannot be immunized)**

I have been given a copy and have read, or have had explained to me, information about the H1N1 influenza and the vaccine 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 requested and ask that the vaccine be given to my children. I acknowledge that I have received a copy of the "Privacy Practices Notices" of Public Health-Madison and Dane County. I understand that I can withdraw my consent at any time by calling my child's school

**I WANT** my child to receive H1N1 flu vaccine at his/her school's immunization clinic.  
 Parent/Guardian signature: \_\_\_\_\_  
 Date: \_\_\_\_\_

**I DO NOT WANT** my child to receive H1N1 flu vaccine at his/her school's immunization clinic.  
 Parent/Guardian signature: \_\_\_\_\_  
 Date: \_\_\_\_\_

***This section for office use only***

Vaccine	VIS Date	Route	Site	Lot Number
H1N1 Influenza	2009-2010	IM/Intranasal	RV LV RD LD	

Person Administering Vaccine Signature & Title: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/2009