Outagamie County Est. 1851

Health and Human Services
Public Health Division
Outagamie County Government Center
320 S. Walnut St., Appleton, WI 54911-5918
Telephone 920.832.5100 Fax 920.832.4924

VACCINE ADMINISTRATION RECORD

Consent to Receive Influenza Vaccine

PLEASE PRINT

LAST NAME:	FIRST NAME: MIDDLE INITIAL:		PARENT NAME	
STREET ADDRESS:	CITY:	STATE:	ZIP:	COUNTY:
DATE OF BIRTH / AGE	SOCIAL SECURITY NUMBER (optional) see below		SEX:	
_____/_____/_____			MALE / FEMALE	

Outagamie County Public Health enters all the vaccine information above into the Wisconsin Immunization Registry (WIR). Providing your social security number allows you to look up your child's vaccination history on WIR. Other medical providers have secure access to view your child's vaccination history but not their SS#. If you do not wish to share your child's immunization history with other medical providers who use WIR please mark here: ☐

I have read or have had explained to me the information about influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to the child named above for whom I am authorized to make this request.
Signature of person authorized to make the request (parent or guardian).

X_____ **Date:** _____/_____/_____

HIPAA FORM MUST BE SIGNED ON THE BACK (OVER)

PLEASE ANSWER (CIRCLE) Y OR N TO QUESTIONS BELOW:

1. Is your child ill today or do they have a fever? **Y or N**
2. Any problems with previous flu vaccinations? **Y or N**
3. Is your child allergic to eggs, chicken, chicken feathers, chicken dander, Thimerosal (such as contact lens solution), phosphate saline, Formaldehyde, Octylphenol Ethoxylate (Triton® X-100), Sucrose? **Y or N**
4. Does your child have any active neurological problem that is not diagnosed or not stable at this time? **Y or N**
5. Does your child have a history of paralysis with Guillain-Barre' Syndrome? **Y or N**

Reviewed by: _____

For Clinic/Office Use
Brand Name: Manufacturer: Lot#: Exp.
Site of injection: LD RD Route: IM
RN Signature: Date:
Paid $____ _____Cash _____Check

Clinic Site (circle): Riverview Middle School Kaukauna High School

Public Health
Prevent. Promote. Protect.

Outagamie County
Department of Health and Human Services

Notice of Privacy Practices
Acknowledgement Cover Sheet

Please have the consumer complete this cover sheet, and then remove it and place it in the consumer's case file.

I, _____ (have consumer write name or request staff assistance), hereby acknowledge that I received the Outagamie County Department of Health and Human Services Notice of Privacy Practices**.**

Signature: _____
Date: _____/_____/_____

If signed by person other than client, state relationship and authority to do so.

Client Name: _____

Client is: ☐ **Minor** ☐ **Incompetent** ☐ **Disabled** ☐ **Deceased**

Legal Authority:
- ☐ **Custodial Parent**
- ☐ **Legal Guardian**
- ☐ **Executor of Estate of Deceased**
- ☐ **Authorized Legal Representative**
- ☐ **Power of Attorney for Healthcare**