FREE
FLU VACCINATIONS

Oconto County Public Health will be at **Gillett Secondary School on October 28th, 2021** offering influenza vaccines to all students.

- The Flu vaccine is **FREE** for all students
- Receiving vaccinations at school saves time and money
- All students are eligible, no insurance information needed
- This is a limited time offer and only available in schools
  (as part of a Preparedness activity)

Complete the consent form and return to school by Wednesday, September 15th, 2021

Please note that the school flu vaccine clinics may be cancelled or rescheduled with short notice due to Public Health staffing related to the COVID-19 pandemic. Public Health and/or your school will inform parents of changes to the school clinics.

FLU VACCINE CONSENT FORM

CHECK ONLY ONE

☐ **Give my child the FluMist (nasal spray)** →

Fill out form and return to school

☐ **Give my child the Flu shot (in the arm)** →

Student Name (Last, First, Middle initial) please print			Male Female
Date of Birth	Age	Parent/Guardian Name	Telephone Number
Address	City		State Zip Code
Race (person to be vaccinated): ☐ American Indian or Alaska Native ☐ Asian ☐ White ☐ Native Hawaiian or other Pacific Islander ☐ Black/African American ☐ Other Race			
Does your child have? ☐ Insured, Vaccines Covered ☐ Native American Heritage ☐ No Health Insurance ☐ Insured, Vaccines Not Covered ☐ MA/Badger Care			
School **Gillett MS/HS**	**Grade**	**Teacher**	

Circle Yes or No

Does the child have any allergies to medications, food, a vaccine component or latex? List:_____.	Yes	No
Has the child had a serious reaction to a vaccine in the past?	Yes	No
Has the child had a health problem with heart, lung (including asthma), kidney, liver, metabolic disease (e.g. diabetes), or blood disorder?	Yes	No
If the person to be vaccinated is a child age **2 through 4 years**, in the past 12 months, has a healthcare provider told you the child had wheezing or asthma? ***If yes, NOT eligible for FluMist.***	Yes	No
Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	Yes	No
Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems? Has the child ever had Guillain-Barre syndrome?	Yes	No
In the past 3 months, has the child taken medications that affect the immune system, such as cortisone, prednisone, other steroids, anticancer drugs; or had radiation treatments?	Yes	No
Has the child received influenza antiviral medications in the last 14 days?	Yes	No
Is the child receiving aspirin therapy or aspirin-containing therapy?	Yes	No
Is the person to be vaccinated pregnant or could she become pregnant within the next month?	Yes	No
Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g. an isolation room of a bone marrow transplant unit)?	Yes	No
Has the child received any vaccination in the past 4 weeks? List:_____	Yes	No

CONSENT FOR VACCINATION: I have read, or have had explained to me, the Vaccine Information Statement for the vaccine (www.OCPH.info). 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 Flu vaccine be given to the person named above for whom I am authorized to make this request. Oconto County Public Health Department will bill Medical Assistance/BadgerCare if the child is covered by those programs. I understand that a record of this immunization may be shared through the Wisconsin Immunization Registry (WIR) and with other health care providers directly involved with the vaccinated person's care. A copy of this consent form is as valid as the original.

Signature X_____ **Date** _____

Data Entry _____/_____ Billing _____/_____ WIR_____/_____

Office Use Only

Is child well today? Y N Route IM Nasal Body site RD LD _____

Vaccine Administrator Initials _____ Date: _____

Notes:

_____

_____

_____

_____

_____

_____

VIS Influenza Inactivated 08/06/21 VIS Live Influenza 08/06/21

12 years old and older ONLY

Consent and Administration Record –COVID-19 Vaccine

Name of my Child's School: _____ Grade: _____ Classroom/Teacher: _____

☐ **Pfizer COVID-19 vaccine (both doses in a 2-dose series, separated by 3 weeks)**

Information about Student Receiving Vaccine(s) – Please Print			
Student Last Name:	**First Name:**		**MI:**
Street Address:	**City:**	**State:** WI	**Zip:**
Date of Birth (MM/DD/YY):	**Age:**	**Mother's Maiden name**	

Gender:
☐ Male ☐ Transgender – Male to Female ☐ Transgender – Female to Male
☐ Female ☐ Transgender – Unspecified or Gender Non-Specific ☐ Prefer not to Answer ☐ Other _____

Race: (check all that apply)	**Ethnicity**
☐ Asian ☐ American Indian or Alaskan Native ☐ White	☐ Hispanic
☐ African American or Black ☐ Native Hawaiian or other Pacific Islander	☐ Non-Hispanic
☐ Prefer not to Answer ☐ Other _____ ☐ Multi-race	☐ Prefer not to Answer

Parent / Legal Guardian Last Name:	**First Name:**	**Phone Number:** (Where you can be reached on date of clinic)

☐ **Pfizer COVID-19 vaccine (both doses in a 2-dose series, separated by 3 weeks)**

	The following questions will help us to determine if there is any reason your child should not receive the COVID-19 vaccine. If you answer "yes" to any questions, it does not necessarily mean that your child should not be vaccinated. It just means that additional questions must be asked for your child's safety. **Questions about the student receiving vaccine:**	**Yes**	**No**
1	Is the student currently in isolation or quarantine period due to COVID-19?		
2	Has the student ever received a dose of COVID-19 vaccine?		
3	Has the student ever had a severe allergic reaction (anaphylactic) to any food, medication, vaccine, or previous COVID-19 vaccine? List:_____		
4	Has the student received antibody therapy or convalescent plasma for COVID-19 treatment in the past 90 days?		
5	Has the student received any vaccines in the past 14 days?		
6	Is the student pregnant or breastfeeding?		

CONSENT FOR VACCINATION: I certify that I am: the legal guardian of the patient or a person authorized to consent on behalf of the patient where the patient is not otherwise competent or unable to consent for themselves. I have read, or have had explained to me, the COVID-19 Vaccine Emergency Use Authorization (EUA). I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the COVID-19 vaccine requested. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). Further, I acknowledge that I have been advised that the patient should remain near the vaccination location for observation for approximately 15 minutes after administration. On behalf of the patient, the patient's heirs and personal representatives, I hereby release and hold harmless each applicable provider, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims where known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above. I understand that a record of this immunization may be shared through the Wisconsin Immunization Registry (WIR) and with other health care providers directly involved with the vaccinated person's care. I authorize use of this consent to be utilized for multiple dose vaccine(s).

_____ _____
Signature of Parent/Legal Guardian Date Signed

_____ _____
Printed Name of Parent/Legal Guardian Relationship to Child

For Office Use Only

Date/Time	Dose	Vaccine	Lot Number	Expiration Date	Site	Signature & Title – person administering vaccine
	☐ 1ST Dose	Pfizer COVID-19 0.3 mL IM	☐ See Cold Chain	☐ See Cold Chain	☐ RD ☐ LD	MM/DD/YYYY
	☐ 2nd Dose	Pfizer COVID-19 0.3 mL IM	☐ See Cold Chain	☐ See Cold Chain	☐ RD ☐ LD	MM/DD/YYYY

Comments: _____