To be Completed by all Participants

PRINT NAME _____

MRN# n/a

DOB _____

DATE OF SERVICE _____

OR LABEL

IMMUNIZATION CONSENT FORM

Fond du Lac Regional Clinic, Fond du Lac, WI

	Yes	No	Unsure
1. Please check which applies to your child: (18 years and younger): ❑ Child is enrolled in Medicaid ❑ Child is an American Indian or Alaska Native ❑ Child has no insurance ❑ Child has insurance, but it does not cover vaccinations (should be immunized at the county) ❑ N/A			
2. Are you sick or ill with a fever today?			
3. Do you have allergies to medications or a vaccine component?			
4. Have you ever had a serious reaction after receiving a vaccination?			
5. Are you allergic to eggs or any food product?			
6. If your child is a baby, have you ever been told he or she has had intussusception?			
7. Have you received any vaccines within the last month or do you plan to receive any within the next month?			
8. Are you allergic to latex?			
9. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (i.e. diabetes), anemia, or other blood disorder, or on longer term ASA?			
10. Do you or a family member have cancer, leukemia, AIDS, HIV, received an organ transplant or any other immune system problem?			
11. Do you take currently or in the past 3 months taken medications that affect the immune system such as: cortisone, prednisone, other steroids, or anticancer drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?			
12. Have you, a sibling, or a parent had a seizure or brain or other nervous system problem?			
13. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?			
14. Have you ever had Guillain-Barre Syndrome?			
15. For women: are you pregnant or is there a chance you could become pregnant during the next month?			

Statement of Informed Consent:

I have read the information regarding the vaccination I or my dependent am to receive. I have had a chance to ask questions which were answered to my satisfaction. I understand both the benefits and the risks of the vaccine and request that it is given to myself/this dependent for whom I am authorized to make this request. This information will be shared with the Wisconsin Immunization Registry. I have received a vaccine information sheet.

_____

NAME (PRINT)

_____

SIGNATURE OF PERSON RECEIVING VACCINE / LEGAL REPRESENTATIVE / RELATIONSHIP TO

_____

DATE **TIME**

Consent

Please continue to the backside or page 2 of this form.

Please staple pages together if not printed on both sides.

IMMUNIZATION CONSENT FORM

Fond du Lac Regional Clinic, Fond du Lac, WI

FRC 2970 PAGE 2 OF 2
ORDER FROM PRINTING

PRINT NAME _____

MRN# n/a

DOB _____

DATE OF SERVICE _____

OR LABEL

To be Completed by Agnesian HealthCare Flu Clinic Staff:

STICKERS OR LOT NUMBERS/EXPIRATION *(patient does not need to sign by each immunization)*

DtaP,IPV,Hep B (Pediarix): _____

DTaP/DT/Td/Tdap: (Boostrix/Infanrix): _____

DTaP & IVP (Kinrix): _____

IPV: _____

MMR: _____

MMR/Varivax (Proquad): _____

Varicella (Varivax): _____

Shingles (Zostavax/Shingrix): _____

Hepatitis A(Havrix/VAQTA): _____

Hepatitis B (Recombivax): _____

Pneumococcal 13 (Prevnar): _____

Pneumococcal 23 (Pneumo Vac): _____

Influenza: _____

Haemophilub B (Pedvax Hib): _____

RotaTeq (Rotavirus): _____

HPV (Gardasil): _____

Meningococcal (Menveo/Menactra): _____

Meningococcal (Bexsero): _____

Yellow Fever: _____

Japanese Encephalitis: _____

Other: _____

VIS DATES

Anthrax	01/08/20
Diphtheria, tetanus and pertussis	08/24/18
Hib	10/30/19
Hepatitis A	07/20/16
Hepatitis B	08/15/19
HPV	10/30/19
Influenza	08/15/19
Japanese Encephalitis	08/15/19
Measles, mumps and rubella	08/15/19
Measles, mumps and rubella/varicella	08/15/19
Meningococcal ACWY	08/15/19
Meningococcal B	08/15/19
Pneumococcal polysaccharide	10/30/19
Pneumococcal conjugate	10/30/19
Inactivated polio vaccine	10/30/19
Rabies	01/08/20
Rotavirus	10/30/19
Multiple - DTap, Hib, Hep B, Pneumoccocal, Polio, Rotavirus	11/05/15
Td	04/11/17
Tdap	02/24/15
Varicella (chicken pox)	08/15/19
Zoster, Recombinant - RZV (Shingles)	10/30/19
Zoster, Live - ZVL (Shingles)	10/30/19

Other: _____

Other: _____

ADDITIONAL DOCUMENTATION FOR FLU CLINIC ONLY:

Manufacturer: _____

Lot#: _____ Exp: _____

Influenza Vaccine: ❑ .5mL administered IM ❑ .25mL administered IM

❑ R deltoid ❑ L Deltoid ❑ R thigh ❑ L thigh

Date: _____ Time: _____

Administered by: _____

Entered into: ❑ Cerner ❑ WIR

Reviewed by: (signature) _____

Date: _____ **Time:** _____

Consent