

Authorization To Receive Tetanus, diphtheria, acellular pertussis (Tdap), Meningococcal Conjugate (MCV4) and/or Human Papilloma Virus (HPV) Vaccine(s)

Information collected on this form will be used to document authorization for receipt of Tdap, varicella, MCV4 and/or HPV 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 vaccines(s):

Check ALL that apply: Tdap (Tetanus, diphtheria, acellular pertussis) vaccine

MCV4 (Meningococcal conjugate) vaccine

HPV9 (Human papilloma virus) vaccine – series 3 vaccinations, a new permission will be sent home for the 2nd and 3rd vaccination.

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:	DATE OF BIRTH:
ADDRESS:	CITY:	STATE:	ZIP:
TELEPHONE NUMBER:		GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
Insurance Status (Check all that apply): <input type="checkbox"/> Insured, Vaccines Covered <input type="checkbox"/> BadgerCare			
<input type="checkbox"/> Native American or Alaskan Native <input type="checkbox"/> Insured, Vaccines Not Covered <input type="checkbox"/> No Health Insurance			
School: <input type="checkbox"/> Chequamegon <input type="checkbox"/> Phillips <input type="checkbox"/> Prentice <input type="checkbox"/> Saint Anthony's			
The following questions will help us determine if there is any reason we should not administer vaccinations.			
<input type="checkbox"/> Yes <input type="checkbox"/> No Is the child sick today?			
<input type="checkbox"/> Yes <input type="checkbox"/> No Does the child have allergies to medications, food, a vaccine component, or latex?			
<input type="checkbox"/> Yes <input type="checkbox"/> No Has the child ever had a serious reaction to a vaccine in the past?			
<input type="checkbox"/> Yes <input type="checkbox"/> No Is the child pregnant or is there a chance she could become pregnant during the next month?			
I have been given a copy and have read, or have had explained to me, information about Tdap, MCV4, and HPV9 and the 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 requested and ask that the vaccine be given to the person named above for whom I am authorized to make this request. I understand that I cannot be charged an administration fee or asked for any type of donation for the administration of the vaccine(s).			
X _____		_____	
SIGNATURE		DATE	

OFFICE USE ONLY

<u>Clinic Site/Date Administered</u>		
<input type="checkbox"/> Prentice School – 9/12/2016	<input type="checkbox"/> Chequamegon School – TBD	Other Date:
<input type="checkbox"/> Phillips School – 9/14/2016	<input type="checkbox"/> Saint Anthony's School – TBD	
<input type="checkbox"/> Tdap Manufacturer: GSK Lot #: TBD Exp. Date: TBD Route: IM Site: <input type="checkbox"/> RD <input type="checkbox"/> LD VIS: 2/24/2015	<input type="checkbox"/> MCV4 Manufacturer: Sanofi Pasteur Lot #: TBD Exp. Date: TBD Route: IM Site: <input type="checkbox"/> RD <input type="checkbox"/> LD VIS: 3/31/2016	<input type="checkbox"/> HPV9 Manufacturer: Merck Lot #: TBD Exp. Date: TBD Route: IM Site: <input type="checkbox"/> RD <input type="checkbox"/> LD VIS: 3/31/2016
Signature of Vaccine Administrator: _____		
<input type="checkbox"/> WIR		