Eau Claire City-County
Health Department

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Consent to Receive Influenza (Flu) Vaccination

PLEASE READ: If any of the following statements applies to you, we will not be able to give you a flu shot.

- If you or anyone in your household is quarantining or isolating due to COVID19
- If you or anyone in your household is experiencing any of the symptoms below:
  - **Headache, fever, cough, chills, shortness of breath, vomiting, diarrhea, nausea, fatigue, loss of taste or smell, sore throat, congestion, or runny nose.**

For children ages 6 months – 8 years old: Children in this age group who are getting vaccinated for the first time or who have only ever had one flu shot, should get two doses of vaccine this year (spaced 4 weeks apart).

Important: Answer the three questions below, fill out **ALL** information, and sign the form.

I give permission for the patient listed below to receive a Flu (Influenza) Shot ☒

***Does the patient below have allergies to a vaccine component or to latex?**	☐ Yes	☐ No
***Has the patient below had a serious reaction to a vaccine in the past?**	☐ Yes	☐ No
***Has the patient below had brain or other nervous system problems?**	☐ Yes	☐ No

Patient's Name (Last, First, Middle Initial)		**Mother's Maiden Name (Last, First, Middle Initial)**			
Address		**City**	**County**	**State**	**Zip Code**
Main Phone ( )	**Alternate Phone** ( )	**Date of Birth**	**Age**	**Gender** ☐ Male ☐ Female	
Race ☐ African American ☐ Asian ☐ Native Hawaiian/Pacific ☐ White ☐ American Indian/Alaskan Native ☐ Other			**Ethnicity** ☐ Hispanic or Latino ☐ Non-Hispanic or Latino		
Name of Parent/Guardian Responsible for Patient (Last, First, MI)			**Relationship to Patient**		

I have been given a copy and have read, or have had explained to me, information about the disease and 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 the person above whom I am authorized to make this request. I give permission to share the patient's immunization records including those provided to school(s) with the Wisconsin Immunization Registry and my Immunization Provider for the purpose of maintaining a complete and accurate record to assist in assuring full immunization.
Check here ONLY if you do NOT give your permission to share with the Wisconsin Immunization Registry. ☐

SIGNATURE – (Parent or Guardian if for a child under 18 years) X	**Date**

FOR OFFICE USE - Please list Insurance information here if an adult vaccination:
Medicare Advantage Plan (HMO only):
Medica Advantage Plan # ________________ Humana Advantage Plan #______________
Security Advantage Plan # ________________ **Medicare** # ________________

Amount Billed: $40.00 **Cash** or **Check** (circle one) Amount paid $___________

Signature and Title of person administering vaccine:	**Date**

Vaccine	**Route**	**Site**	**Dose**	**Mfr/Lot No.**	**Clinic Site (Circle one)**
Influenza	IM	RV LV RD LD	1 2	**GSK**	**Augusta** **Sports Center** **Shelter** **ECCHD**