Return to Main Office at School

ADOLESCENT CLINIC
EAU CLAIRE CITY-COUNTY HEALTH DEPARTMENT
Authorization to Receive Vaccinations

Information collected on this form will be used to document authorization for receipt of vaccinations 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 vaccination schedule.

My signature below authorizes my child to receive this vaccine:

Check all that apply →

- ☐ Influenza injection
- ☐ HPV (Gardasil)
- ☐ Meningococcal (Meningitis)
- ☐ Tdap

Patient's Name (Last, First, Middle Initial)	**Mother's Maiden Name (Last, First, Middle Initial)**

Address	**City**	**County**	**State**	**Zip Code**

Cell Number/Home Number ( )	**Age & Date of Birth (mm/dd/yyyy)**	**Gender** ☐ Male ☐ Female

Race (Check one)
- ☐ African American
- ☐ Asian
- ☐ White
- ☐ American Indian or Alaskan Native
- ☐ Native Hawaiian/Pacific
- ☐ Other

Ethnicity
- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Latino

Name of Physician	**Name of School**	**Grade**

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 my child'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. ☐

SIGNATURE – (Parent or Guardian for children under 18 years)	Date

FOR OFFICE USE				
Vaccine	Route	Site	Dose	Mfr/Lot No.
Influenza	IM IN	RV LV RD LD	1 2 1 2	
Tdap	IM	RV LV RD LD	1	
Meningococcal	IM	RV LV RD LD	1 2	
HPV	IM	RV LV RD LD	1 2 3	
Signature and Title of person administering vaccine:			Date:	
School Clinic Site (circle one):	DMS	NSMS	SMS	Fall Creek Fairchild Community Center