DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-00048 (08/2016)

STATE OF WISCONSIN
Wis. Stats. 252.04

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

Information collected on this form will be used to document authorization for receipt of Tdap, MCV4, HPV, and/or Influenza 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 the following vaccine(s). Check all that apply:

☐ Tdap (Tetanus, diphtheria, acellular pertussis) vaccine [**Required** (1 dose)]
☐ MCV4 (Meningococcal conjugate) vaccine [**Recommended** (2 doses)]
☐ HPV (Human papilloma virus) vaccine [**Recommended** (3 doses)]
☐ Flu Vaccine (Influenza) [**Recommended Annual** (1-2 doses)]

Patient's Name (Last, First, Middle Initial) | Date of Birth (mm/dd/yyyy)

Address | P. O. Box | City | County | State | Zip Code

Home Telephone Number ( ) | Mother's Maiden Name | Sex ☐ Male ☐ Female

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

Ethnicity (Check one)
☐ Hispanic or Latino
☐ Non-Hispanic or Latino

Eligibility Status - This section must be completed. (Check all that apply)

☐ **Native American** ☐ **Badger Care** ☐ **Insured, Vaccines Covered**
☐ **Medicaid Eligible** ☐ **No Health Insurance** ☐ **Insured, Vaccines Not Covered**

Name of Physician | Name of School | Grade

Name of Parent or Guardian Responsible for Patient (Last, First, Middle Initial) | Relationship to Patient

Okay to share immunization data with Wisconsin Immunization Registry (WIR)? ☐ Yes ☐ No

I have been given a copy and have read, or have had explained to me, information about the disease(s) and 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(s) requested and ask that the vaccine(s) be given to me or to the person named above for whom I am authorized to make this request.

Wisconsin Medicaid restricts billing recipients for any covered service(s). I understand that if I am a Medicaid/BadgerCare recipient I cannot be charged an administration fee or asked for any type of donation for the administration of any vaccine that is being provided.

SIGNATURE - Person to receive vaccine or person authorized to sign on the patient's behalf. | Date Signed

X

FOR OFFICE USE

Tdap: route= IM site (circle one) RD or LD dose number= 1
Manufacturer/Expiration_______________________________________ Lot No. ____________________ VIS date: 2/24/15

MCV4: route= IM site (circle one) RD or LD dose number= 1 or 2
Manufacturer/Expiration_______________________________________ Lot No.____________________ VIS date: 3/31/2016

HPV: route= IM site (circle one) RD or LD dose (circle one) 1 or 2 or 3
Manufacturer/Expiration_______________________________________ Lot No.____________________ VIS date: 3/31/2016

Flu: route = IM site (circle one) RD or LD or RV or LV dose (circle one) 1 or 2 VIS date: 8/7/2015
Manufacturer/Expiration_______________________________________ Lot No. ____________________

Signature and title of person administering vaccine:______________________________ Date vaccine administered: ______________

LHD clinic address:____