City of Milwaukee Health Department

Parent's Consent to Vaccinate in Clinic (H-548-OS)

Child's Name	Date of Birth	Age	Sex	School or Childcare
			M F	

Child's race: *(☑ all that apply)*

☐ Black/African American ☐ White ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander

Child's ethnicity: *(☑ only one)*	Insurance: *(☑ one)*
☐ Hispanic or Latino	☐ No Health Insurance ☐ Public Insurance *(BadgerCare, Medicaid, T-19, etc.)*
☐ Not Hispanic or Latino	☐ Private Health Insurance. *Does child's insurance cover vaccines?* ☐ *Yes* ☐ *No* Name of Private Insurance: ______________________________

I want my child to receive the following vaccines: *(☑ one box below left. If you do not mark a box, only the required vaccines for school/childcare will be given.)*

☐ **Only vaccines required for school/childcare attendance.** *(See other side for required vaccines.)*

☐ **In addition to required vaccines, please give my child** *(check all that apply)*

☐ Influenza ☐ COVID-19 ☐ Hepatitis A ☐ HPV ☐ Meningococcal ACWY (MCV4) ☐ Meningococcal type B (Men B)

Please answer all questions by checking "yes" or "no". If you answer "yes," please provide a brief explanation. Your answers will help us know what vaccines we may safely give your child. If any questions are not clear, please call the **MHD Immunization Program at (414) 286-6800.**

IS THE PERSON RECEIVING THE VACCINE TODAY:	
1. Sick / running a fever within 12 hours of completing this questionnaire?	☐ Yes ☐ No
2. Pregnant or planning pregnancy in the next 3 months?	☐ Yes ☐ No
3. Have a history of seizures, convulsions, epilepsy, Guillain-Barre or any other nervous system or brain problems?	☐ Yes ☐ No
4. Allergic to foods, medications, ointments, latex, eggs, gelatin, Thimerosal (mercury containing product), polyethylene glycol (PEG), polysorbate, or any other substances?	☐ Yes ☐ No
5. Have a history of serious problems or reactions (including neurological symptoms) with previous immunizations?	☐ Yes ☐ No
6. Received any blood/blood products, immune globulin, or monoclonal antibodies in the past year?	☐ Yes ☐ No
7. Received any vaccine or TB skin test in the past 30 days?	☐ Yes ☐ No
8. Have any problem with immune system (including HIV, AIDS, cancer, kidney disease, leukemia, bone marrow/organ transplant, etc.?)	☐ Yes ☐ No
9. On steroids, aspirin therapy, blood thinners, other medications / have a bleeding disorder / receiving radiation therapy?	☐ Yes ☐ No
10. Living with or in close contact with anyone who has had any conditions listed in #8 or #9 above?	☐ Yes ☐ No
11. Was baby's birth weight less than 2,000 gr. (4 lb. 7 oz.)?	☐ Yes ☐ No

I understand that Vaccine Information Sheets (VIS) about the vaccines given to my child to prevent the diseases listed will be given out on the date that the immunizations are provided. I also understand that I may get and read these VIS online at **www.immunize.gov/vis** before the scheduled clinic date, and that I may call the MHD if I have any questions about any vaccines at **(414) 286-6800**. As required by privacy regulations, I hereby acknowledge that I have received or reviewed a current copy of this provider's "Notice of Privacy Practices."

I understand that my child will receive vaccinations from the City of Milwaukee Public Health Nurses (PHNs). Although serious reactions are extremely rare, I will allow MHD PHNs to give my child Diphenhydramine (Benadryl) or Epinephrine if my child has a severe adverse reaction to a vaccination. A record will be kept of all treatment given to my child. If my child needs emergency treatment, I give my permission for him/her to be transported to a hospital.

In accordance with Wisconsin State Statute 262.04 and Chapter HFS 144, I understand that all immunization-related information may be shared with Milwaukee Public Schools and the State of Wisconsin. I consent to entry of my child's vaccination records into the Wisconsin Immunization Registry (WIR), and agree to allow immunization information from WIR to be given to my child's school or childcare center. I agree to allow immunization information to be released to our family physician, any medical referral service, and/or insurance companies. My signature below also gives permission to the MHD to bill Medicaid (Title 19) for all applicable immunization services. I will not be asked to pay for any services provided by the MHD. By signing this consent form, I understand that I am obligated to notify the MHD or my child's school or childcare facility of any changes to my child's immunization status.

Name of Parent/Guardian ______________________________ Home Phone ______________________

Address ______________________________ Work Phone # ______________________

In the case that your child does not feel well after vaccination, please provide contact information for an alternate person if you cannot be reached.

Name ______________________________ Relationship to child ______________________

Address ______________________________ Phone # ______________________

Signature of Parent or Guardian ______________________________ **Date signed** ______________________

Vaccines Required for School or Childcare Attendance

These vaccines are required by State of Wisconsin law for entrance and attendance in schools and childcare.

SCHOOL	CHILDCARE
Diphtheria, Tetanus, Pertussis (DTap/Td/Tdap)	Diphtheria, Tetanus, Pertussis (DTap/Td/Tdap)
Measles, Mumps, Rubella (MMR)	Measles, Mumps, Rubella (MMR)
Polio (IPV)	Polio (IPV)
Hepatitis B (HepB)	Hepatitis B (HepB)
Varicella (Var) Chickenpox	Varicella (Var) Chickenpox
	Haemophilus influenzae type b (Hib)
	Pneumococcal (PCV)

Vaccines Recommended in Addition to those Required for School or Childcare

These vaccines protect children against 6 common serious diseases in the State of Wisconsin that are not listed in the required vaccines above. They are highly recommended by MHD and can be given in addition to the required vaccines above. Please call the MHD Immunization Program at (414) 286-6800 if you have questions about these additional vaccines.

TYPE OF VACCINE	BENEFIT OF THE VACCINE	RECOMMENDED AGE
Influenza (Flu)	Protects against seasonal flu	Beginning at age 6 months
COVID-19	Protects against COVID-19	Beginning at age 6 months
Hepatitis A (Hep A)	Protects the liver against a hepatitis A virus, which can be spread through poor food handling	Beginning at age 12 months
Human Papilloma Virus (HPV)	Protects against certain types of cancer in men and women	Routinely administered at 11-12 years of age, but may be started at age 9.
Meningococcal (MCV4)	Protects adolescents against meningitis caused by meningococcal strains A, C, W, and Y	Beginning at age 11 years
Meningococcal type B (Men B)	Protects late adolescents against meningitis caused by meningococcal type B strain	Beginning at age 16 years

Not receiving vaccines in school or childcare?

1. Please make sure your child's school or childcare has an up-to-date copy of all required vaccines for school or childcare attendance.
2. If your child has not received all required vaccines, please take your child to your healthcare provider or MHD Walk-in Clinic. (See attached handout for MHD Walk-In Clinic times and locations or call the MHD Immunization Program at 414-286-6800 for Walk-in Clinic information.)
3. If you do not want your child to receive certain required vaccines for medical, religious or personal reasons, be advised that ***your unvaccinated child will be excluded from school or childcare during a disease outbreak until the outbreak is over.*** It may take from 2 weeks to several months before an outbreak is over.