



School Based Health Program
950 N. 12th Street
Suite A627
Milwaukee, WI 53233

T (414) 219-7748
F (414) 219-7709

www.AuroraHealthCare.org

CONSENT FOR CHILD IMMUNIZATIONS

Dear Parents or Guardians:

The Aurora's School Based Health Program (ASBH) will be offering **free** immunizations in your child's school. Your child will only receive immunizations if they have a signed consent form like the one below. A separate form must be filled out for each child.

ASBH will notify you in advance of the date and time a clinic will be conducted in your child's school. In case your child needs an immunization some time during the coming year, please fill out this form (front and back) and return it to the school office today. You may cancel this consent at any time, but it must be in writing with your signature and the date of cancellation.

I give permission for my child:

(Name) _____ at

(Name of School): _____ to receive all required immunizations as deemed appropriate by the ASBH program.

Immunizations that may be given include those to protect children against the following illnesses: Diphtheria, Tetanus, Pertussis, Polio, Haemophilus Influenzae type B, Pneumococcal-related diseases, Hepatitis A, Hepatitis B, Meningococcal-related diseases, Human Papilloma Virus, Measles, Mumps, Rubella, Varicella.

Statements (VIS) regarding vaccines against these diseases (the VIS sheets with this form). I understand that I may call the ASBH program at 219-7748, if I have any questions about any vaccines.

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I understand my child will receive these services from the ASBH nurses. I will allow the ASBH nurse to give my child Diphenhydramine (Benadryl) or Epinephrine if my child has an adverse reaction (rash, cough, difficulty breathing) to a vaccination. A record will be kept of all treatment given to my child. If my child needs emergency treatment, I give permission for my child to be transported to a hospital.

In accordance with Wisconsin State Statute 252.04 and Chapter HFS 144, I understand that all immunization related information may be shared with Milwaukee Public Schools and the State of Wisconsin. I agree to allow immunization information to be released to our family physician, any medical referral service, and/or insurance companies.

Your child cannot be immunized by an ASBH nurse without a signed consent form. Please fill out BOTH SIDES of this form and sign, date, and return it to your child's school today.

PRINTED Name of Parent/Guardian

Relationship to Child

*Signature of Parent/Guardian

Date Signed

*This consent is valid for ONE YEAR from the date signed.

Vaccine Screening Questionnaire

Child's Name _____ Date of Birth _____

Please answer the following questions about your child. Your answers will help us determine what vaccines we may safely give your child. Please circle "yes" or "no". If you answer "yes," please provide a brief explanation. If any questions are not clear, please call the Aurora School Based Health Program at 219-7748.

1. Has your child had a seizure, brain, or nerve problem? Yes No
If Yes, please explain: _____

2. Does your child have allergies to food, medications, ointments, latex, Thimerisol or any vaccine? Yes No
If Yes, please explain: _____

3. Has your child had a serious reaction to a vaccine in the past? Yes No
If Yes, please explain: _____

4. Has your child received any transfusions of blood or blood products, or been given a medicine called immune (gamma) globulin in the past year? Yes No
If Yes, please explain: _____

5. Does your child have cancer, leukemia, AIDS, or any other immune system problem? Yes No
If Yes, please explain: _____

6. Has your child taken steroids, aspirin therapy, other medications, or x-ray treatments within the last year? Yes No
If Yes, please explain: _____

7. Is your child living with or in close contact with anyone who has a problem with the immune system, or who is currently taking steroids, ongoing aspirin therapy, or x-ray treatments? Yes No
If Yes, please explain: _____

8. Has your child's biological mother ever been diagnosed with Hepatitis B? Yes No
If Yes, please explain: _____

Signature of Parent / Guardian

Date Signed

Address of Parent / Guardian

Zip Code

Work Phone

Home Phone

Cell Phone

*If my child does not feel well after receiving immunizations and I cannot be reached, please contact the person listed below.

Name

Relationship to child

Address

Phone