WIR Data Entry Date_____________ Staff________

City of Milwaukee Health Department

Consent and Administration Record – School-Based COVID-19 Immunization Clinic

Health Department Address: 841 N. Broadway, 3rd Floor, Milwaukee, WI 53202

Name of my Child's School: ______________________________ Grade: ________ Classroom/Teacher: ________________

Information about Student Receiving Vaccine(s) – Please Print			
Student Last Name:	**First Name:**		**MI:**
Street Address:	**City:**	**State:** WI	**Zip:**
Date of Birth (MM/DD/YY):	**Age:**	**Mother's Maiden name:**	

Gender: ☐ Male ☐ Transgender – Male to Female ☐ Transgender – Female to Male
☐ Female ☐ Transgender – Unspecified or Gender Non-Specific ☐ Prefer not to Answer ☐ Other _________

Race: (check all that apply)
☐ Asian ☐ American Indian or Alaskan Native ☐ White
☐ African American or Black ☐ Native Hawaiian or other Pacific Islander
☐ Prefer not to Answer ☐ Other_____________________ ☐ Multi-race

Ethnicity:
☐ Hispanic
☐ Non-Hispanic
☐ Prefer not to Answer

Parent / Legal Guardian Last Name:	**First Name:**	**Phone Number:** (Where you can be reached on date of clinic)

I understand the benefits and risks of the vaccine and ask that the vaccine be given to the child listed above for whom I am authorized to make this request. I GIVE CONSENT to the City of Milwaukee Health Department and its staff for my child named at the top of this form to be vaccinated with this vaccine. By signing this consent, I GIVE CONSENT that my child will receive the first and second part of the vaccine series. I also consent to have their vaccine information entered into the Wisconsin Immunization Registry (WIR).

☐ **Pfizer COVID-19 vaccine (both doses in a 2-dose series, separated by 3 weeks)**

The following questions will help us to determine if there is any reason your child should not receive the COVID-19 vaccine. If you answer "yes" to any questions, it does not necessarily mean that your child should not be vaccinated. It just means that additional questions must be asked for your child's safety.

	Questions about the student receiving vaccine:	**Yes**	**No**
1	Is the student currently in isolation or quarantine period due to COVID-19?		
2	Has the student ever received a dose of COVID-19 vaccine?		
3	Has the student ever had a severe allergic reaction (anaphylactic) to any food, medication, vaccine, or previous COVID-19 vaccine? List:____		
4	Has the student received antibody therapy or convalescent plasma for COVID-19 treatment in the past 90 days?		
5	Has the student received any vaccines in the past 14 days?		
6	Is the student pregnant or breastfeeding?		

____ ______________________
Signature of Parent/Legal Guardian Date Signed

____ ______________________
Printed Name of Parent/Legal Guardian Relationship to Child

FOR OFFICE USE ONLY **Date/Time**	**Dose**	**Vaccine**	**Lot** Number	**Expiration Date**	**Site**	**Signature & Title –** person administering vaccine
	☐ **1st Dose** ☐ **2nd Dose**	Pfizer COVID-19 0.3 mL IM			☐ **RD** ☐ **LD**	MM/DD/YYYY

Second Dose Information: Date: _________________**Time**:___________ **am/pm**
Comments:

Date EUA fact sheet for recipients and caregivers provided to parent/guardian: