**Health Department**
729 Clay Street
Darlington, WI 53530
P. 608-776-4895
F. 608-292-7009

Fall 2025

Dear Parent or Guardian:

The Lafayette County Health Department is working with your child's school to give the seasonal **flu vaccine and/or any other needed immunization**s to children through a partnership with O'Connell Pharmacy. ***All vaccines require parent or guardian permission.***

Vaccine information statements and vaccine information can be found at the following links. Home | Immunize.org and Vaccine Basics | Vaccine Information

Please call the Health Department for any questions about vaccine or the vaccination clinics.

*If you ***want*** your student vaccinated, complete the permission form, select vaccines wanted and **return to school ASAP.**

**If you ***do not wish*** your child to be vaccinated **do not return the form to school.**

**Please see the Fall Vaccine Clinic Schedule below for dates and times available for all school and community vaccine clinics. You may register for one of the Open to ALL clinics using the QR CODE below or click this link.** Immunization Community Clinic**.**

Sincerely,

Lafayette County Health Department

****Attention**! Need vaccines? Not sure? Give us a call! 608-776-4895**
**Insurance, no insurance.....we got you!**

***Lafayette County Fall Vaccine Clinic Schedule***

| | | | |
|---|---|---|---|
| **If you or someone you know is homebound, please call to make arrangements for a vaccine home visit.** | | 11/13/2025 8:30-9:30 AM | Belmont School — **Students & Staff ONLY** |
| 11/4/2025 9:00-10:00 AM | Blackhawk School — **Open to ALL** | 11/13/2025 9:30-10:30 AM | Belmont Apartments 351 South Mound Ave — **Open to ALL** |
| 11/4/2025 11:00-5:30PM | Multipurpose Building Darlington — **Open to ALL** | 11/13/2025 1:00-4:00 PM | Argyle School — **Open to ALL** |
| 11/5/2025 8:30-9:30 AM | Benton School — **Students & Staff ONLY** | 11/14/2025 9:00-10:30 AM | Hollandale School — **Students & Staff ONLY** |
| 11/5/2025 10:00-12:00 PM | Beginning Point Church Benton — **Open to ALL** | 11/14/2025 11:00-1:00PM | Blanchardville Library — **Open to ALL** |
| 11/5/2025 1:00-4:00 PM | Shullsburg School — **Open to ALL** | 11/14/2025 1:15-2:15 PM | Pecatonica School — **Students & Staff ONLY** |
| 11/6/2025 8:30-11:30 AM | Darlington EM School — **Students & Staff ONLY** | 11/13/2025 2:30-4:00 PM | Blanchardville- Riverview Apts 303 Maple Street — **Open to ALL** |

# *Informed Consent for Vaccination*

Last Revised: 10/2025

**Patient Information:** ***please print clearly****

Last Name: _____ First Name: _____

Date of Birth: _____ Phone Number: _____

Address: _____ City: _____ State: _____ ZIP: _____

Gender at Birth: _____ Gender Identification: _____

Race: ☐ White ☐ Black/African American ☐ American Indian/Alaska Native* ☐ Asian ☐ Native Hawaiian/Pacific Islander

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Prescription Drug Insurance Name: _____

RxBIN: _____ RxPCN: _____

RxID: _____ RxGroup: _____

Medicare ID (if applicable): _____

ForwardHealth ID* (if applicable): _____

Medical Health Insurance Name: _____

ID: _____ Group: _____

**For Office Use ONLY:**
*(fill out for all persons under age 19)*

VFC Eligible?

☐ YES ☐ NO

Reason?

_____

## Vaccine Eligibility Screening Questions:

Do you have one or more severe allergies to latex, medications, food, vaccines, or general allergies?
☐ NO ☐ YES – *Please Describe:* _____

Have you ever had a severe reaction to receiving a vaccination?
☐ NO ☐ YES – *Please Describe:* _____

Have you been diagnosed with a seizure, brain, or other nervous system problem?
☐ NO ☐ YES – *Please Describe:* _____

Have you been diagnosed with a bleeding disorder, or are you currently taking a blood thinner (except Aspirin)?
☐ NO ☐ YES – *Please Describe:* _____

Do you have any underlying chronic conditions (such as asthma, COPD, diabetes, heart disease, etc)?
☐ NO ☐ YES – *Please Describe:* _____

Do you have an immunocompromising condition as defined under the FDA or EUA guidelines?
☐ NO ☐ YES – *Please Describe:* _____

Are you breastfeeding, currently pregnant or planning on becoming pregnant in the next month?
☐ NO ☐ YES – *Please Describe:* _____

Have you received immunoglobulin, antibodies, or any vaccination in the last four weeks?
☐ NO ☐ YES – *Please Describe:* _____

**Do you feel sick today, including any upper respiratory issues *(Pharmacy to Ask on Day of Vaccination)*?**
☐ NO ☐ YES – *Please Describe:* _____

**Have you been diagnosed with or been in contact with any communicable disease in the last 21 days?**
☐ NO ☐ YES – *Please Describe:* _____

## Parent/Guardian/Legal Guardian Information – please print, (*if applicable*):

Last Name: _____ First Name: _____ Phone: _____

## Legal Statement:

I certify that I am:

☐ The patient and at least 18 years old
☐ The parent/guardian/legal guardian of the patient (listed above)
☐ A third party or health care personnel taking a verbal authorization on behalf of the patient; or patients legal guardian (listed above)

Date of Verbal Authorization: _____ Time of Verbal Authorization: _____

I hereby give my consent for O'Connell Pharmacy, LTD. pharmacist, technician, resident, nurse, or the intern under the direct supervision of a pharmacist to administer the vaccine(s) requested. I understand the risks and benefits associated with the vaccine(s) and have received, read and/or had explained to me the Vaccine Information Statements or Emergency Use Authorization Form associated with the vaccine(s) received. I hereby release and hold harmless O'Connell Pharmacy, LTD. and its employees and collaborative practice physicians from any and all liabilities or claims known or unknown in any way related to administration of the vaccine(s). I consent to O'Connell Pharmacy, LTD. reporting the vaccination(s) information to the immunization registry and releasing my medical information to my healthcare professionals, partnered software vendors, Medicare, Medicaid, and any other 3rd party payer as necessary to facilitate payment. **I understand that this encounter may be billed to my pharmacy insurance, medical insurance, or both. I further agree to be fully financially responsible for any due amounts, including copays, coinsurance, and deductibles.**

**Signature:** _____ **Date:** _____

**Complete back page as well!**

Child's Name: _____ Date of Birth: _____

Does your child need vaccines? If you know which vaccine(s) and would like them given at school, check the below and return. We will double check the Wisconsin Immunization Registry. If you are not sure, check with your school or the Health Department at 608-776-4895 or publichealth@lafayettecountywi.org. Only send this form back to school if you want your child vaccinated.

| | | |
|---|---|---|
| | ***Flu/Influenza*** ***(Age 6 months+)*** (FLUZONE TRIV) | *Recommended.* *Not required for school.* |
| | ***Tdap*** ***(Age 10+)*** **(Tetanus, Diphtheria, Pertussis)** (BOOSTRIX) | ***Required for entrance into 7th grade.*** |
| | ***Meningitis*** ***(Age 11+)*** Meningococcal ACWY (MENQUADFI) | ***Required for entrance into 7th grade.*** ***Booster required in 12th grade.*** |
| | ***HPV*** ***(Age 11+)*** **(Human Papilloma Virus)** (GARDASIL 9) | *Recommended.* *Not required for school.* |
| | ***Meningitis B*** ***(Age 16+)*** (Meningococcal ABCWY) (PENBRAYA) | *Recommended for 16+* *Not required for school.* |
| | ***Hepatitis B*** ***(Any Age)*** (ENERGIX-B) | ***Required when a child starts school.*** |
| | ***Measles, Mumps, Rubella*** ***(Age 1+)*** **(MMR)** (Priorix) | ***Required when a child starts school.*** |
| | ***Varicella (Chickenpox)*** ***(Age 1+)*** (Varivax) | ***Required when a child starts school.*** |
| | ***Polio*** ***(Age 1+)*** (IPOL) | ***Required when a child starts school.*** |
| | ***Varicella + MMR Combo*** ***(Age 4+)*** (PROQUAD) | ***Required when a child starts school.*** |
| | ***Covid-19*** ***(Age 6 months+)*** (Pfizer COMIRNATY) | *Recommended.* *Not required for school.* |

If you do **not** want your child vaccinated, do **not** send this form back to school.