



Health Department

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

Fall 2026

Dear Parent or Guardian:

The Lafayette County Health Department is working with your school district to give the seasonal flu vaccine to students at school. Flu vaccinations will be provided, FREE of charge, to school aged children (3-18 years of age). The flu vaccine requires parent or guardian permission.

We will be at your child's school on: **October 23, 2026**

For seasonal flu vaccine information statements, please visit the CDC's influenza web pages at:

<https://www.cdc.gov/vaccines/hcp/vis/vis-statements/flu.html>

If you have any questions about the vaccine or the vaccination clinics, please contact us at 608-776-4895.

If you want your student vaccinated, complete the permission form and **return to school by October 21, 2026.**

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

Sincerely,

Lafayette County Health Department

Lafayette County Health Department

**** DO NOT RETURN** this form if you **do not want** your child to receive a vaccination at the school based clinic.

Information collected on this form will be used to document permission for your child to receive the seasonal influenza vaccine at your child's school. Record of this immunization may be shared through the Wisconsin Immunization Registry (WIR) with other health care providers directly involved with your child's care.

SCHOOL: BLACKHAWK

Student's Name (Last, First, Middle initial)				Gender ☐ Male ☐ Female	
Student's Birthdate Month _____ Day _____ Year _____		Student's Age	School Grade	Parent/Guardian Daytime Phone Number ()	
Home Address		P.O. Box	City	County	State Zip Code
Parent/Guardian's Name			Okay to share immunization data with the Wisconsin Immunization Registry (WIR) ? ☐ YES ☐ NO		

Please answer the following questions (circle Yes or No):

1. Does your child have a serious allergy to eggs?	YES	NO
2. Does your child have any other serious allergies? Please list:	YES	NO
3. Has your child ever had a serious reaction or allergic response to past flu vaccinations?	YES	NO
4. Has your child ever had Guillian Barré syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	YES	NO

**If you answered YES to any of the above questions, please contact your doctor for the flu vaccination.*

CONSENT FOR CHILD'S VACCINATION:

I would like my child to receive the influenza vaccine.

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I have read, or have had explained to me, the Vaccine Information Statement for seasonal influenza vaccine. 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 be given to the student named above for whom I am authorized to make this request.

Signature: X _____ Date: _____

FOR OFFICE USE			VIS date: 01/31/2025	
Route = IM		Body site (circle one) = RD or LD / RV or LV		Dose (circle one): 1 or 2
Manufacturer:	Sanofi Pasteur	Lot No. _____	Date vaccine administered:	10/23/2026
Signature and title of person administering vaccine: _____				
Revised: 10/01/26				