Please Print:

OZAUKEE COUNTY PUBLIC HEALTH DEPARTMENT
VACCINE ADMINISTRATION RECORD/CONSENT FORM

Name: ______________________________ Date of Birth: __________ Age: ______

(Last Name, First Name, Middle Initial)

Street Address: ______________________________ Phone: __________

City/State/Zip: ______________________________ ☐ Male ☐ Female

COMPLETE ONLY IF YOU ARE A MEDICARE/ADVANTAGE PLAN OR MEDICAID/BADGERCARE CARDHOLDER

☐ Medicare Part B Number: ______________________________ ☐ Medicaid/Badgercare

☐ Medicare Advantage Plan Insurance Provider: ______________________________

Member/Subscriber ID Number : ____________________ Group #: ____________

- **Please have your Medicare/Advantage Plan card available for Public Health staff to verify**

Please answer the following questions:	**Yes**	**No**
1. If this person is a child, are you the parent or guardian?		
2. Are you sick today with an illness more severe than a cold?		
3. Do you have a serious life-threatening allergy to Thimerosol (a mercury antiseptic/preservative), latex, eggs, monosodium glutamate, gelatin, gentamicin, arginine, polymyxin B, or neomycin?		
4. Have you ever had a reaction to a flu vaccine?		
5. Do you have any of the following medical conditions: respiratory (asthma), cancer, immunosuppression, blood disorder, pregnancy, or a child/teen receiving aspirin therapy or aspirin products? **(Can't receive Flu Mist)**		
6. Have you ever been paralyzed with Guillain-Barre Syndrome?		
7. Do you get faint or light headed when receiving a "shot" or having blood testing?		
8. Have you received any vaccines or antiviral medications in the last four weeks or are you planning on having any vaccinations?		
Please Answer if you are Pregnant: 9. Do you have a prescription with you from the physician providing your pregnancy care? *Note: If you are pregnant, you cannot receive the live form of the influenza vaccine.*		

Note: Your immunization may be placed in the Wisconsin Immunization registry, WIR. WIR helps your health care provider in record-keeping and tracking vaccines. Immunization information may be shared with health providers, PHD, schools, etc. according to WI State policy.

I have been given a copy and have read, or had explained to me, information about the privacy practices and the vaccine that I will be receiving. I understand the benefits and risks of the vaccine and ask that this vaccine be administered to me or the person for whom I am authorized to make this request. I also understand the cost of this vaccine is my responsibility and any balance not covered by Medicare/Advantage Plan will be billed to me directly.

Signature of Client or Guardian: ______________________________ Date: __________

Interviewed By: ______________________________ RN Date: __________

CDC VIS	Vaccine Manufacturer	Lot	Site
INFLUENZA – TIV / LIAV	SF / NV / CSL GSK / MM		RD LD IN RV LV

RN Signature: ______________________________ **Date Administered**: __________

Vaccine Administrator

Clinic Site: ____________________ **Billing**:Flu-$10/$28/$40 Amount Paid__________ **BILL:** ☐