WEST ALLIS HEALTH DEPARTMENT
INFLUENZA VACCINE ADMINISTRATION RECORD (MINOR)

Part I. Personal Information for Person to Receive Vaccine – PLEASE PRINT

Last Name | **First Name** | **MI:**

Street Address | **Apt #**

City | **State** W I | **Zip Code**

Area Code — **Phone** —

Birth Date (MM/DD/YYYY) / / **Age**

Gender: (check one)

in (check one) ☐ years ☐ months ☐ Male ☐ Female

For people younger than 18 years of age:
Name of Parent or Guardian

Last Name | **First Name** | **MI**

Mother's Maiden Name | **Relationship to Patient** _____

RACE (CHECK ONE)
❑ American Indian or Alaska Native ❑ Asian ❑ Native Hawaiian or other Pacific Islander
❑ Black or African American ❑ White ❑ Other Race

ETHNICITY:
❑ Hispanic ❑ Non-Hispanic

Check all that apply:
❑ Native American ❑ Badger Care ❑ Insured, Vaccines Not Covered
❑ Medicaid Eligible ❑ No Health Insurance ❑ Insured, Vaccines Covered
❑ Mass Clinic

Medicaid Number

Part II. Consent

Wisconsin Medicaid restricts billing recipients for any covered service(s). I understand that if I am a Medicaid/BadgerCare recipient I cannot be charged an administration fee or asked for any type of donation for the administration of any vaccine that is being provided. I have been offered a copy of the City of West Allis Privacy statement and have had a chance to ask questions. I authorize the release of this information to Medicaid, to process this claim.

I have been given a copy and have read, or have had explained to me, information about Influenza and the Influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the Influenza vaccine and ask that the vaccine(s) checked below be given to me or to the person named above, for whom I am authorized to make this request.

NOTE: Immunization history will be placed in the **Wisconsin Immunization Registry (WIR)** to help your health care provider in record-keeping and tracking future vaccines that may be needed. Immunization information may be shared with other providers, public health departments, schools and health insurers in accordance with the laws of the State of Wisconsin. You must notify the West Allis Health Department in writing if you do not wish this information to be shared.

X _____ / / _____

SIGNATURE of person to receive vaccine or person authorized to sign on behalf of the person who will receive required vaccines(s). **DATE**

Please turn page over and answer the questions on the back of this form.

West Allis Health Department

Name of Person Receiving Vaccine _____
(Last, First, Middle Initial)

Age of Person Receiving Vaccine: _____

Part III. Medical Information: Mark (X) "Yes" or "No" for questions 1-8

Is / Does the person receiving the vaccine today:

1. Sick / running a fever?	❒ Yes ❒ No
2. Age six months through 8 years old? If yes, have they received flu immunizations in the past?	❒ Yes ❒ No ❒ Yes ❒ No
3. Have a serious allergy to **eggs**, egg products, thimerosal (mercury-containing product), gentamycin, gelatin, other foods, medications, ointments, latex or another substance?	❒ Yes ❒ No
4. Have a history of seizures, convulsions, epilepsy, Guillain-Barre or any other nervous system or brain problems?	❒ Yes ❒ No
5. Have a history of serious problems or reactions (including neurological symptoms) with previous immunizations?	❒ Yes ❒ No
6. Have a bleeding disorder?	❒ Yes ❒ No
7. Have long-term health problems such as heart, lung, kidney or liver disease, or metabolic diseases such as diabetes?	❒ Yes ❒ No
8. Have a weak immune system (including HIV, AIDS, cancer, kidney disease, leukemia, or medications such as steroids)?	❒ Yes ❒ No

For Official Use Only

❑ **Child will need 2nd flu dose this season.**

	AGE GROUP	DOSAGE	TODAY'S DOSE IS:	ROUTE
❑	6 months – 35 months	0.25 ml.	1 or 2	IM
❑	3 – 8 years	0.50 ml.	1 or 2	IM
❑	9 – 12 years	0.50 ml.	1	IM
❑	> 12 years	0.50 ml.	1	IM

❑	**West Allis employee Child (private pay vaccine)**

Screener's Signature_____ **Date:** ☐☐ / ☐☐ / ☐☐☐☐

Administration

Manufacturer: ☐ **Sanofi Pasteur** ☐ **GSK**	**Dose:** ☐ **.25 ml** ☐ **.5 ml**	**Site:** ☐ **RD** ☐ **LD** ☐ **RV** ☐ **LV**
Lot # (place sticker here) **VIS Statement (08/07/2015)**	**Administered by:** _____ **Date:** ☐☐ / ☐☐ / ☐☐☐☐	

8/2017