WEST ALLIS HEALTH DEPARTMENT INFLUENZA VACCINE ADMINISTRATION RECORD

Information About the Person to Receive Influenza Vaccine – *PLEASE PRINT*

Last Name: **Legal First Name:** **MI:**

Address: **Apt #**

City: **State:** WI **Zip Code:** **Gender: (check one)** ☐ Male ☐ Female

Area Code: **Phone:** **Birth Date:** / / **Age:**

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

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/Medicare, to process this claim. **The West Allis Health Department reserves the right to bill for the cost of influenza vaccine if not reimbursed by insurance provider.*

HEALTH HISTORY QUESTIONS FOR INFLUENZA VACCINE	YES	NO
Do you have a fever of 100.4°F or greater today?		
Have you ever had a serious reaction to a previous influenza vaccination?		
Are you allergic to EGGS, egg products, thimerosal (mercury-containing product), Gentamicin, Polymyxin B, Neomycin, gelatin, latex or another substance?		
Have you ever been paralyzed with Guillain Barré Syndrome?		

I have been offered a copy of the Vaccine Information Statement (VIS) and have read, or have had explained to me, information about 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 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 _____ **Date:** / /

Signature ☐ **Self** ☐ **Parent** ☐ **Guardian** ☐ **POA**

Office Use Only:

AGE GROUP	PRODUCT	AGE GROUP	PRODUCT	AGE GROUP	PRODUCT
❑ 6 mos. – 8 yrs.	Quad	❑ 18 yrs. – 64 yrs.	Quad	❑ 65 yrs. – up	Quad
❑ 9 yrs. – 18 yrs.	Quad			❑ 65 yrs. – up	High Dose Quad

☐ WA Employee ☐ WA Employee spouse or child ☐ Waived ☐ Paid

☐ WM Employee ☐ Retiree/Spouse ☐ WEA / ☐ Non-WEA (School District Employee)

Do you belong to one of the following Medicare Advantage Plans? If yes, which plan?

❑ AARP Medicare ❑ United Health Care ❑ Humana or Choice Care ❑ BlueCross

Health Insurance:

❑ Medicaid Eligible / BadgerCare ❑ No Insurance ❑ Medicare ❑ Insured – Vaccine covered ❑ Insured – Vaccine not covered ❑ MASS CLINIC

Medicare / Medicaid Number:_____

VACCINE	ROUTE	SITE OF INJECTION	DOSE #	Manufacturer	Dose	Lot Number	Expires
Fluzone High Dose Quad	IM	LD RD	1	Sanofi-Pasteur	.7 ml		
FLUARIX Quad – Mass/VFC	IM	LD RD LVL RVL	1 / 2	GlaxoSmithKline	.5 ml		
FluLaval Quad	IM	LD RD LVL RVL	1 / 2	GlaxoSmithKline	.5 ml		
Afluria Quad	IM	LD RD	1	Seqirus	.5 ml		

***Does child (6 mos. – 8 yrs.) need 2nd flu dose this season? ❑ Yes ❑ No**

Screener's Signature_____ **Vaccinator's Signature**_____