Public Health
MADISON & DANE COUNTY
Healthy people and places

Vaccine Administration Record and Screening FLU ONLY

Information collected on this form will be used to document authorization for receipt of vaccines. The information will be shared through the Wisconsin Immunization Registry (WIR) with other health care providers directly involved with the patient to assure completion of the vaccine schedule. Information collected on this form is voluntary. If you have questions please consult the immunization clinic staff. **Please Print.**

Person receiving vaccine: Last Name:_____ **First Name:** _____ **Middle:** _____

Mother's Maiden: Last Name_____ **First Name**_____

Date of Birth: month:_____ day:_____ year:_____ **Age:**_____ **Gender:** ☐ Male ☐ Female

Social Security Number_____(used to look up your own record)

Address:_____ **City:**_____ **Zip:**_____ **Telephone:**_____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic **Race:** ☐ Black/ African American ☐ American Indian ☐ Asian ☐ White ☐ Other Race

Health Insurance: ☐ Insured w/Vaccines ☐ Insured/ No Vaccines ☐ None ☐ Medical Assistance (Forward card)

I have been given a copy and have read, or have had explained to me, information about the diseases and the vaccine to be received. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine requested and ask that the vaccine be given to my child. I acknowledge that I have received a copy of the "Privacy Practices Notices" of Public Health-Madison and Dane County.

Questions for person receiving vaccine	**Yes**	**No**
1. Are you sick today?	☐	☐
2. Do you have any allergies to medications, foods (especially eggs), vaccines, thimerosal, or latex? List	☐	☐
3. Do you have a history of ever had Guillain-Barré Syndrome? (Temporary paralysis)	☐	☐
4. Have you had a serious reaction after receiving a vaccination?	☐	☐

𝑋 **Signature:**_____ **Date:** _____

Office use only

Vaccine	VIS Date	VIS given	Route	Site	Trade name/Manufacturer Lot Number	Expiration Date
Influenza	8/6/2021		IM	RV LV RD LD		

Signature and Title – Person Administering Vaccine:_____ Date:_____