



100 Polk County Plaza, Suite 180
 Balsam Lake, WI 54810
 (715) 485 8500

2019-2020 INFLUENZA VACCINE ADMINISTRATION RECORD

I have read or have had explained to me the information in the vaccine information statement 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 and ask that the vaccine be given to me, or the person named below for whom I am authorized to make this request. I have also received the Notice of Privacy Practices for the Polk County Health Department.

VIS Date: Flu: 8-15-19

Information about person to receive vaccine. (Please print)					
Name: Last	First	Middle Initial	Birth Date	Age	Phone
Address: Street		City	State	Zip	County
Your Medical Clinic—circle or name: Amery St. Croix Osceola VA Other: _____ None					
Is the person to be vaccinated sick today? Know			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't
Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine? Know			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't
Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? Know			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't
Has the person to be vaccinated ever had Guillain-Barré syndrome? Know			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't
Signature of person to receive vaccine or person authorized to make the request (parent or guardian) and authorization to release this information to Medicare Part B, BadgerCare or Health Insurance to process this claim.					
X _____			Date _____		

Health Insurance Information

Insurance Plan Name _____

Subscriber Name _____ ID # _____

Group Name _____ Group # _____

*****Vaccine Administration*****

Location & Date: Balsam Lake _____ Other _____

Influenza Vaccine Mfr. & Lot No.: _____ Site of Injection: (L) Deltoid (R) Deltoid

Signature of PHN/RN: _____