2011

## Crawford County Health Department Influenza / Pneumonia Administration Record

| WIR   |  |
|-------|--|
| INVCD |  |
| PAID  |  |

The doctor or clinic may keep this record in your medical file or your child's medical file. They will record what vaccine was given, when the vaccine was given, the name of the company that made the vaccine, the vaccine's special lot number, the signature and title of the person who gave the vaccine, and the address where the vaccine was given.

I have read or have had explained to me the information about influenza and 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 influenza vaccine and ask that the vaccine be given to me or the person named below from whom I am authorized to make this request.

## PLEASE PRINT

|   | EASE PKI             |         |                  | 1 2 1 15              | 210   | . TTS //             |                                       |                  |          |                      |          | 01.101                 | CD OI                          |          |             |             |  |  |
|---|----------------------|---------|------------------|-----------------------|-------|----------------------|---------------------------------------|------------------|----------|----------------------|----------|------------------------|--------------------------------|----------|-------------|-------------|--|--|
| 1. MEDICARE # circle one at right   |                      |         | 2. MEDICAID #    |                       |       |                      |                                       |                  |          |                      |          |                        | POLICY GROUP NAME circle one   |          |             |             |  |  |
|   |                      |         |                  |                       |       |                      |                                       |                  |          |                      |          | 1. HUMANACHOICE        |                                |          |             |             |  |  |
| Patient's given name: (Last name, first name, middle initial)   |                      |         |                  |                       |       |                      | Age:                                  |                  |          |                      |          | 1. MEDICAL ASSOCIATES  |                                |          |             |             |  |  |
|   |                      |         |                  |                       |       |                      |                                       |                  |          |                      |          | 1. SENIOR PREFERRED    |                                |          |             |             |  |  |
|   |                      |         |                  |                       |       |                      | Patients DOB:                         |                  |          |                      |          | 1. UCARE               |                                |          |             |             |  |  |
| N it  |                      |         |                  |                       |       |                      |                                       |                  |          |                      |          | 1. GUNDERSEN LUTHERAN  |                                |          |             |             |  |  |
| Name as it appears on insurance card:   |                      |         |                  |                       |       |                      | Sex WEA                               |                  |          |                      |          |                        |                                |          |             |             |  |  |
|   |                      |         |                  |                       |       |                      |                                       | M   F  PdC       |          |                      |          |                        |                                |          |             |             |  |  |
| Street address:   |                      |         |                  |                       |       |                      | Patients Maiden Name Seneca           |                  |          |                      |          |                        |                                |          |             |             |  |  |
|   |                      |         |                  |                       |       |                      | WSHS                                  |                  |          |                      |          |                        |                                |          |             |             |  |  |
|   |                      |         |                  |                       |       |                      | Dot                                   | iont rolati      | ionshin  | to incure            | d        |                        |                                |          |             |             |  |  |
| City  |                      |         | State<br>WI      |                       |       |                      | Patient relationship to insured  self |                  |          |                      |          | Name of insured person |                                |          |             |             |  |  |
| · ·   |                      |         |                  | W I                   |       |                      |                                       | sen              |          |                      |          |                        |                                |          |             |             |  |  |
| Zip code  |                      |         | Telephone / Cell |                       |       |                      |                                       | □spouse          |          |                      |          |                        | ☐ Influenza                    |          |             |             |  |  |
| _   |                      |         |                  |                       |       |                      |                                       | □child           |          |                      |          |                        | <ul><li>Pneumococcal</li></ul> |          |             |             |  |  |
|   |                      |         |                  |                       |       |                      |                                       | Cillia           |          |                      |          |                        |                                |          |             |             |  |  |
| Have you eve  | er had a sever       | e react | tion to th       | ne influenza          | vac   | cine? Y              | es                                    | No Ur            | ık       |                      |          |                        |                                |          |             |             |  |  |
| A #12 1/21/ 21/#12  | eriencing any        | farran  |                  |                       | :f.   | otion? V             | Yes                                   | No I             | Jnkno    |                      |          |                        |                                |          |             |             |  |  |
| Are you expe  | mencing any          | ievei ( | or upper         | respiratory           | IIIIC | cuon:                | 168                                   | NO C             | JIIKIIO  | WII                  |          |                        |                                |          |             |             |  |  |
| Are you aller   | gic to eggs, th      | nimero  | sal or la        | ntex? Yes             | No    | Unk                  | Hav                                   | e you e          | ver ha   | d Guilli             | an Bar   | re Syr                 | ndrome?                        | Yes      | No U        | Jnk         |  |  |
| Signature of pe   | erson to receive     | vaccii  | ne or ner        | son authorize         | d to  | make the t           | reane                                 | est (naren       | it or gu | ardian) s            | and auth | norizat                | tion to rel                    | ease thi | s inform    | nation      |  |  |
|   | ate billing vend     |         |                  |                       | u to  | make the i           | cque                                  | st (paren        | it of gu | arurair) a           | and auti | 101124                 | non to ici                     | case un  | 5 111101111 | ation       |  |  |
| To the street   | 8                    | F       |                  |                       |       |                      |                                       |                  |          |                      |          |                        |                                |          |             |             |  |  |
| Signature   |                      |         |                  |                       |       |                      | Date:                                 |                  |          |                      |          |                        |                                |          |             |             |  |  |
|   |                      |         |                  |                       |       |                      | 2011                                  |                  |          |                      |          |                        |                                |          |             |             |  |  |
|   |                      |         |                  |                       |       |                      |                                       |                  |          |                      |          |                        |                                |          |             |             |  |  |
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| Clinic/Office   |                      |         |                  |                       |       |                      |                                       |                  |          |                      |          |                        |                                |          |             |             |  |  |
| Date  |                      |         |                  |                       |       |                      |                                       |                  |          |                      |          |                        |                                |          |             |             |  |  |
| Time  |                      |         |                  |                       |       |                      |                                       |                  |          |                      |          |                        |                                |          |             |             |  |  |
| phone:  |                      |         |                  |                       |       |                      |                                       |                  |          |                      |          |                        |                                |          |             |             |  |  |
| Clinic/Office   |                      |         |                  |                       |       |                      |                                       |                  |          |                      |          |                        |                                |          |             |             |  |  |
| Date<br>Time  |                      |         |                  |                       |       |                      |                                       |                  |          |                      |          |                        |                                |          |             |             |  |  |
| phone:  |                      |         |                  |                       |       |                      |                                       |                  |          |                      |          |                        |                                |          |             |             |  |  |
| Clinic/Office   |                      |         |                  |                       |       |                      |                                       |                  |          |                      |          |                        |                                |          |             |             |  |  |
| Date Date   |                      |         |                  |                       |       |                      |                                       |                  |          |                      |          |                        |                                |          |             |             |  |  |
| Time  |                      |         |                  |                       |       |                      |                                       |                  |          |                      |          |                        |                                |          |             |             |  |  |
| phone:  |                      |         |                  |                       |       |                      |                                       |                  |          |                      |          |                        |                                |          |             |             |  |  |
|   |                      |         |                  | 7770                  |       | T.T.C                |                                       | *****            |          |                      |          |                        |                                |          |             |             |  |  |
| VFC   | VFC                  | VFC     |                  | VFC                   |       | VFC                  | VFC                                   |                  | VFC      |                      | Novartis |                        | Pneur<br>Mercl                 |          |             |             |  |  |
| MedImmune   | San Pasteur          | San     | Pasteur          | San Paster            | ır    | San Paste<br>Fluzone |                                       |                  |          | Novartis<br>Fluvirin |          | Fluvirin<br>1100701    |                                | ovax 23  |             |             |  |  |
| FLU MIST<br>12/18/11  | Fluzone Pfree        |         |                  | Fluzone               | 12    |                      | /12                                   |                  |          |                      |          |                        |                                | Exp      | ovax 23     |             |  |  |
|   | Exp 6/30/12          | _       | 6/30/12          | Exp 6/30/             |       | Exp 6/30             |                                       | Exp 6/3          |          | Exp 6/               |          |                        | 5/31/12                        | age 2    | & up        |             |  |  |
| 6 mo & up<br>501105P  | 6-35 mos<br>UT4114BA |         | 6 & up<br>154AD  | 3 yrs & up<br>UT465AA |       | 3 yrs & u<br>UH442A  |                                       | 4 & up<br>110150 |          | 4 & up<br>11102      |          | 4 &<br>1100            | •                              |          | •           | 1           |  |  |
| 501105P         UT4114BA         UH454AD         UT465AA         UH442AB         1101501         111021         1100701           Site of Injection:         LV RV         Left Del.         Right Del. |                      |         |                  |                       |       |                      |                                       |                  |          |                      |          |                        |                                |          |             |             |  |  |
| RN Signature:   | G Wall               | D W     | allin_San        | nder M.R.             | relle | r I Pou              | را1ا<br>اور                           | K Reil           | IIv N    | Hauser               | M Tre    | leven                  |                                |          |             |             |  |  |