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.

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1. MEDICARE # circle one at right 2. MEDI)IC/	CAID#						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						
Nit							,		,	1.	1. GUNDERSEN LUTHERAN						
Name as it appears on insurance card:							Sex	, x	,	/		WEA					
Suite							M D FD PdC										
Street address:						Pat	Patients Maiden Name Seneca										
							WSHS										
G. Jan.							Dot		ما المام ساء	to in							
City			State WI			Patient relationship to insured self					Name of insured person						
W I																	
Zip code			Telephone / Cell				□spouse					☐ Influenza					
								□child					Pneumococcal				
								Cililu									
Have you eve	Have you ever had a severe reaction to the influenza vaccine? Yes No Unk																
Are you experiencing any fever or upper respiratory infection? Yes No Unknown																	
Are you aller	Are you allergic to eggs, thimerosal or latex? Yes No Unk Have you ever had Guillian Barre Syndrome? Yes No Unk																
Signature of pe	erson to receive	vaccir	ne or ner	son autho ri ze	d to	make the i	reane	est (naren	it or gu	ardian) s	and auth	norizat	ion to rel	ease thi	s inform	ation	
	ate billing vend				u to	make the i	cque	st (paren	it of gu	arurair) a	and auti	101124	ion to ici	case un	5 111101111	ation	
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Signature							Date:										
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MedImmune	San Pasteur		Pasteur	San Paster	ır	San Paste	eur San Pasteur		Novartis		Novartis Fluvirin		Mercl				
FLU MIST	Fluzone Pfree	Fluze		Fluzone	.11	Fluzone	Jui		Fluvirin Fluvirin			1100701			ovax 23		
12/18/11	Exp 6/30/12		6/30/12	Exp 6/30/	12	Exp 6/30	/12			Exp 6/30/12				Exp			
6 mo & up	6-35 mos	_	& up	3 yrs & up		3 yrs & u				4 & up		4 & up		age 2	& up		
501105P	UT4114BA		54AD	UT465AA		UH442A		110150		11102		1100	•				
Site of Injection: LV RV Left Del. Right Del.																	
RN Signature: G Wall D Wallin-Sander M Breuer I Powell K Reilly N Hauser M Treleven																	