2022-2023 INFLUENZA VACCINE ADMINISTRATION RECORD

Private Nasal	VFC Nasal
Private IM	VFC IM

NAME (Last)	(First)	(M.I.)	GRADE	TEACHER
PARENT/LEGAL GUARDIAN'S NAME (Last)	(First)	(M.I.)	BIRTH DATE (mm/dd/yyyy) / /	AGE / GENDER M / F / O
ADDRESS			PARENT/GUARDIAN DAYTIME PHONE NUMBER:	
CITY	STATE	ZIP	SCHOOL	

Please answer the following questions by circling "YES" or "NO". We need this important health information to decide if the recipient can receive the influenza vaccine and which form of the vaccine they are eligible for.

Question		
1.Does the individual to be vaccinated have a serious allergy to eggs?	YES	NO
2. Does the individual being vaccinated have asthma?	YES	NO
3. Is the individual being vaccinated pregnant or could be pregnant?	YES	NO
4. Does the individual receiving the vaccination feel sick today? (Fever, symptoms of COVID-19, etc).	YES	NO
5. Does the individual being vaccinated have any other serious allergies? If yes, please list: ____	YES	NO
6. Has the individual being vaccinated ever had a serious reaction to a previous dose of flu vaccine?	YES	NO
7. Has the individual being vaccinated ever had Guillain-Barre Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	YES	NO
8. Has the individual being vaccinated received any other vaccines within the past 30 days? If yes, please indicate type and date. Vaccine: ______________________________ Date given: __/__/_____	YES	NO
9. Is the individual being vaccinated currently on long-term aspirin or aspirin-containing therapy (for example, does your child take aspirin every day)?	YES	NO
10. Does the individual being vaccinated have a weakened immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)?	YES	NO
11. Does the individual being vaccinated have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?	YES	NO
12. Do you prefer the vaccine recipient get one type of vaccine over another? If "YES" check which kind of vaccine below that is preferred. **Note: The individual to be vaccinated may not receive this preferred vaccine if he/she has a medical concern related to the vaccine or if that vaccine is not available.** ________ Flu Mist (intranasal) __________ Injectable (Intramuscular/shot) **If preferred vaccine is not available, do you still want the recipient to be vaccinated? Yes No (Circle One)**	YES	NO

Please circle "YES" or "NO" for each consent item, complete insurance information and sign below. Children will not receive influenza vaccination without a parent or guardian signature.

Consent		
13. I consent to sharing influenza immunization data with the Wisconsin Immunization Registry (WIR) so that the clinic/doctor is aware that the individual being vaccinated has received this vaccine.	YES	NO
14. If the recipient of the influenza vaccine is covered by health insurance, I consent to allow the Polk County Health Department to bill my insurance company for the administration of influenza vaccine. I understand that there is no cost to me. **Please complete this section or attach a copy of insurance information.** Name of Health Insurance Plan/Company: ____ Group # _____________ ID#____________________________ Subscriber's Name_________________________	YES	NO

I have read the Vaccine Information Statements dated 8/6/21 for the influenza vaccine and understand the risks and benefits. By signing this consent form I give permission to the Polk County Health Department to administer influenza vaccine to myself or child listed above.

Signature: ____ Date: _________________________

Date Dose Administered	Route	IM Site	Vaccine Manufacturer Lot Number	Name and Title of Vaccine Administrator
/ /	☐ IM ☐ Intranasal	☐ LD ☐ RD		