Monroe County Health Department
Serving the Community since 1921
315 West Oak Street · Sparta, WI 54656 · (608) 269-8666 · Fax (608) 269-8872

VACCINE ADMINISTRATION RECORD

Please answer each of the following questions: **Have you ever had:**

1. Past serious allergic reaction to any influenza vaccine ❑ Yes ❑ No
2. History of brain or nervous system problems (Guillian-Barre) ❑ Yes ❑ No
3. Current illness with or without fever ❑ Yes ❑ No

Information about person to receive vaccine. (Please Print)

Name: Last First Middle Initial Sex: M F Birth date Age

Mother's Maiden Name:

Address: Street City State Zip Phone

I have read or have had explained to me the information about influenza disease and influenza vaccine and have been given the Vaccine Information Sheet regarding influenza, dated 8/15/2019. I have had a chance to ask questions that were answered to my satisfaction. 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. Information may 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.

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 or other payors to process this claim.

X _____ **Date** _____

INFORMATION NEEDED FOR INSURANCE CLAIM

Medicare #:_____ **Subscriber/ID:** _____

Medicare Advantage Plan (circle): Senior Preferred Humana BCBS Other: _____

Badgercare #: _____

Insurance Plan Name, Phone (circle): BCBS MHS Quartz Security Tricare UHC WEA WPS ICare Health Partners

Subscriber/ID:_____ **Sponsor & DOB:** _____

If your insurance company denies for any reason, i.e. applied to deductible, you will be responsible for the amount billed to your insurance company. PLEASE PROVIDE COPY OF YOUR INSURANCE CARD, FRONT & BACK.

I request that payment of authorized Medicare, Medical Assistance or other payer benefits be made on my behalf to Monroe County Health Department for any services furnished me by that provider.

********For Clinic/Office Use*******

Vaccine	Route:	Site:	Mfr./ Lot/Exp/Dose:	Date:	RN Signature:
Influenza	IM/Nasal	RV LV RD LD			

☐ WIR ☐ BILLED LOCATION