ROCK COUNTY HEALTH DEPARTMENT

VACCINE ADMINISTRATION RECORD

MASS VACCINATION CLINIC

Information collected on this form will be used to document authorization for receipt of vaccine(s). 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. Information collected on this form is voluntary and the Social Security Number will be used by parent or guardian to access the Wisconsin Immunization Registry.

Patient's Name (Last, First, Middle Initial)			**How did you hear about the clinic?** ☐ **email** ☐ **call** ☐ **website** ☐ **newspaper**	
Address	**City**	**County**	**State**	**Zip Code**
Telephone Number	**Date of Birth (mm/dd/yyyy)**	**AGE**	**Gender** ☐ **Male** ☐ **Female**	
Race (check one) ☐ **African American** ☐ **American Indian or Alaskan Native** ☐ **Asian** ☐ **Native Hawaiian/Pacific Islander** ☐ **White** ☐ **Other**			**Ethnicity (check one)** ☐ **Hispanic or Latino** ☐ **Non-Hispanic or Latino**	
Social Security Number (Social Security Number will be used by parent or guardian to access the Wisconsin Immunization Registry)				
Name of Physician			**Name of Clinic**	
Minors Only: Name of Parent or Guardian Responsible for Patient (Last, First, Middle Initial)			**Relationship to Patient**	

Please complete the following health screening questions: Does the person to be vaccinated today:	**YES**	**NO**	**DON'T KNOW**
• **Have any symptoms of illness at the present time?**			
• **Have a history of egg allergy OR adverse reaction to a previous influenza vaccine?**			
• **Take aspirin therapy?**			
• **Have asthma or a history of wheezing in the past 12 months?**			
• **Take antiviral medication?**			
• **Have close contact with someone whose immune system is not working and must be in protective isolation?**			

I have been given a copy and have read, or have had explained to me, information about the disease(s) and vaccine(s) to be received. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine(s) be given to me or to the person above for whom I am authorized to make this request.

I give permission to share mine or my child's immunization records including those provided to School(s) with the Wisconsin Immunization Registry and my Immunization Provider for the purpose of maintaining a complete and accurate record to assist in assuring full immunization.
Check here ONLY if you do NOT give your permission. ☐

SIGNATURE – Must be a parent or guardian signature unless the vaccine recipient is 18 years old or older	**Date Signed**

☐ **Child will need to return for dose 2 – voucher given**
☐ **Child will not need to return for a second dose**

Patient's Name (Last, First)

FOR OFFICE USE

Vaccine	Route	Site Admin. *	Dose Number	Manufacturer	Lot Number	VIS Form Date ✡
☐ Influenza, Flumist	IN**	NA	1 2	MedImmune	☐ CH2023 ☐ CH2063 ☐ CJ2004 ☐ CJ2105 ☐ CJ2126	8/19/14
☐ Influenza, QIV Injectable Preservative Free (0.5 ML)	IM	RV LV RD LD	1 2	FluZone Sanofi-Pasteur	☐ U5010AA ☐ U4996AA ☐ UI171AC	8/19/14
☐ Influenza, QIV Injectable Preservative Free **6-35 months** (0.25 ML)	IM	RV LV RD LD	1 2	FluZone Sanofi-Pasteur	☐ U4978AB ☐ U5018BA	8/19/14

*RV = R Vastus Lateralis, LV – L Vastus Lateralis, RD = R Deltoid, LD = L Deltoid Subcutaneous injections are administered in the muscle "area". **IN = Intranasal

✡ Use most current Vaccine Information Statement (VIS) or if appropriate use the Multi Vaccines Information Statement (VIS).

SIGNATURE AND TITLE – Person Administering Vaccine

Date Vaccine Administered
☐ 11/3/2014
☐ 11/4/2014

CLINIC SITE:
☐ Beloit Turner School Mass Clinic
☐ Clinton School Mass Clinic

Rock County Health Department
3328 US Hwy 51 North, Janesville 61 Eclipse Center, Beloit