VACCINE ADMINISTRATION RECORD

2015 School Flu Clinic

IF YOU DO NOT WANT YOUR CHILD TO RECEIVE THE FLU VACCINE, DO NOT RETURN THIS FORM TO THE SCHOOL

Information about person to receive vaccine. (Please print)
First Name: Middle Initial: Last Name:
Full Birthdate: Male ☐ Female ☐
Address: _____ City_____ Zip_____
Phone Number: Currently on Badgercare? Yes / No
I have been given a copy and have read, or have had explained to me, information about the disease(s) and vaccine(s). I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine(s) be given to me or the person named above for whom I am authorized to make this request. *Please note all vaccine information will be entered into the Wisconsin Immunization Registry (WIR).
Parent or Guardian Signature: Signature:_____ Date:_____

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

Phone: (608) 930-9870

Clinic/Office Address:	Iowa Co. Health Dept., 303 W. Chapel St., Dodgeville, WI 53533	
Vaccine	Injectable	Nasal Mist
Date Vaccine Administered		
Vaccine Lot Number		
Site of Injection	LD RD	
Signature of Vaccine Administrator		
Title of Vaccine Administrator	RN, BSN	

PLEASE NOTE:

Notice of Privacy Practices regarding
Health Information (HIPAA) available at flu clinic