



Name of Person Receiving Vaccine \_\_\_\_\_

(Last, First, Middle Initial)

Age of Person Receiving Vaccine: \_\_\_\_\_

**Part II. Medical Information:** Mark (X) "Yes" or "No" for questions 1-14

**Is / Does the person receiving the vaccine today:**

1. Sick / running a fever?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have a serious allergy to foods, medications, ointments, latex, eggs, gelatin, Thimerosal (mercury-containing product) or an other substance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have a history of seizures, convulsions, epilepsy, Guillain-Barre or any other nervous system or brain problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have a history of serious problems or reactions (including neurological symptoms) with previous immunizations?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have a bleeding disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have asthma, or had one or more episodes of wheezing in the last year?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have long term health problems such as heart, lung, kidney or liver disease, or metabolic diseases such as diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Have a weak immune system (including HIV, AIDS, cancer, kidney disease, leukemia, or medications such as steroids)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Have close contact with anyone with a severely weakened immune system that requires a protective environment (for example, anyone with a recent bone marrow transplant)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. A child or adolescent on long term aspirin therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Received any other vaccines within the last 28 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Currently taking antiviral medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Have a serious blood disorder (such as sickle cell)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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**Education: Medical Information Comments**


**Part IV. Consent**

I have been given a copy and have read about INFLUENZA and the INFLUENZA VACCINE. I believe I understand the benefits and risks of the vaccine. I have been instructed about reasons a person should not get this vaccine, and I (or the person named above, for whom I am authorized to make this request) am not experiencing any condition that would be a reason to not get the requested vaccine. In accordance with Wisconsin State Statute 252.04 and Chapter HFS 144, I understand that all immunization-related information may be shared with the State of Wisconsin. I consent to entry of client's vaccination records into the Wisconsin Immunization Registry. I agree to allow immunization information to be released to our family physician, any medical referral service, and/or insurance companies. My signature below also permits the City of South Milwaukee Health Department (SMHD) to bill Medicaid (Title 19) or Medicare for all applicable immunization services. I will not be asked to pay for any services provided by the SMHD related to this vaccination, and I have been offered a copy of the SMHD Notice of Privacy Practices.

**Patient/Legal Guardian Signature** \_\_\_\_\_

**Date** \_\_\_\_\_