



Influenza

Vaccination

Please fill out the requested information completely:

1) Name: _____ Birthdate: _____

2) Which arm do you want to use: Right Left

3) I am requesting the following quadrivalent flu shot:

Traditional flu shot **\$34.95** Appropriate for Ages 6+

High Dose flu shot **\$89.95** Appropriate and recommended for ages 65+

4) For ages 6-8 only: How many influenza vaccinations has the child had in his/her life?:

None or 1

2 or More

Don't know

5) Allergies:

No allergies

Eggs

Neomycin, Polymyxin, Hydrocortisone or Gentamicin

Other vaccines or vaccine components: _____

Other allergies: _____

6) Are you currently experiencing any acute illness such as a cold or other infection?

No Yes (please describe): _____

7) Have you ever had a serious reaction to influenza vaccine in the past?

No Yes (please describe): _____

8) Have you ever had Guillain-Barre syndrome?

No Yes (if yes, when?): _____

9) We will add a record of this vaccination to the Wisconsin Immunization Registry (WIR) to keep your records with your other health care providers up-to-date. You may decline to be added to WIR; it will then be your responsibility to notify your health care providers as needed.

Do NOT submit a record of this vaccination to the Wisconsin Immunization Registry

10) Please sign and date:

Signature: _____ Date: _____

If you would like us to bill Medicare or insurance for this vaccination, please provide your insurance card(s) with this form.