Public Health
Prevent. Promote. Protect.
Door County

VACCINE CONSENT and ADMINISTRATION/BILLING RECORD

Door County Public Health will keep this record in its medical files
and enter it into the Wisconsin Immunization Registry (WIR).

Information of PERSON TO RECEIVE Vaccine (Please Print Clearly)

Patient's Name	Gender	Date of Birth	**Age**

Mailing Address	City	State	Zip Code

Phone Number

PLEASE ANSWER THE FOLLOWING QUESTIONS (CHECK YES OR NO)

The following questions will help determine if there is any reason vaccine should not be given today. "Yes" answers do not necessarily mean vaccine will not be given, but additional questions must be asked. If a question is not clear, please ask.

	Yes	No
1. Is the person to be vaccinated sick today?	☐	☐
2. Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine(s)?	☐	☐
3. Has the person to be vaccinated ever had a serious reaction to a vaccine in the past?	☐	☐
4. Has the person to be vaccinated ever had Guillain-Barré syndrome?	☐	☐
5. Has the person to be vaccinated had any vaccines in the past 2 months?	☐	☐

I am requesting the following vaccines: ☐ Influenza ☐ Influenza High Dose (ages 65+) ☐ COVID-19

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 named above for whom I am authorized to make this request.

SIGNATURE *of person to receive vaccine or person authorized to sign on the patient's behalf and consent to submit to insurance, if applicable.* **X**	**RELATIONSHIP:**	**DATE SIGNED:**

We accept Medicaid/BadgerCare+, Medicare Part B (without an advantage plan), WI Medicare Advantage Plans—United Healthcare and Humana only, WI Commercial Insurance—Common Ground and United Healthcare only, or cash/check.

Office Use Only

Check the box that applies and provide insurance member ID # where applicable:

☐ Paying by cash or check: ☐ Influenza $50 ☐ High Dose Influenza (65+) $98 ☐ COVID-19 $165

Amount $: _____ Check #: _____

☐ Medicaid/Forward Health – Member ID #: _____

and/or BadgerCare+ HMO Name/Member ID #: _____/_____

☐ Medicare Part B – Member #: ____ ____ ____ ____ - ____ ____ ____ - ____ ____ ____ ____ / State: _____

☐ WI Medicare Advantage – Member ID #: _____ ☐ Humana ☐ United Healthcare

☐ WI Commercial Insurance – Member ID #: _____ ☐ Common Ground ☐ United Healthcare

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Clinic Location: ADRC Sister Bay Washington Island Midwest Wire
Public Health Justice Center Home Visit

Vaccine ***Highlight vaccine(s) patient is requesting***	Route	Site	Manufacturer	Lot Number
INFLUENZA VIS date 1-31-2025	IM	LD, RD	GSK, SP	
HIGH DOSE INFLUENZA (Ages 65+ only) VIS date 1-31-2025	IM	LD, RD	SP	
COVID-19 VIS date 1-31-2025	IM	LD, RD	Pfizer	

Vaccine Administrator (and Credentials) _____ Date_____

Door County Public Health
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