LA CROSSE COUNTY HEALTH DEPARTMENT

La Crosse County Health Department will record what vaccine was given, when the vaccine was given, the name of the company that made the vaccine, the vaccine's special lot number, the signature and title of the person who gave the vaccine and the address where the vaccine was given.

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 below for whom I am authorized to make this request.

INFORMATION ABOUT PERSON RECEIVING VACCINE (Please Print)

Last Name	**First Name**	**MI**	**Sex** M F	**Date of Birth**
Street Address			**City**	
County	**State**	**Zip Code**	**Area Code**	**Telephone Number**

Race
☐ **African American** ☐ **Hispanic/Latino** ☐ **Asian**
☐ **White** ☐ **Native American/Alaskan Native**
☐ **Other** ☐ **Native Hawaiian/Other Pacific Islander**

Regular health care provider/clinic:
☐ **Mayo Clinic Health System- Franciscan**
☐ **Gundersen Lutheran**
☐ **Other**

May we share this information on the Wisconsin Immunization Registry (WIR) so your health care provider has it? ☐ **YES** ☐ **NO**

Mother's Maiden Name: Last / First

☐ **Medicare** ☐ **Badger Care** ☐ **Insured, Vaccine Covered**

☐ **MA** ☐ **No Insurance** ☐ **Insured, Vaccines Not Covered**

Social Security Number (Optional - Required if you wish to access the (WIR) Wisconsin Immunization Registry from home)

Signature of person to receive vaccine or person authorized to make the request (parent/legal guardian) and authorization to release this information to Medicare or Medical Assistance to process this claim.

_____ _____
Patient Signature or Signature of Legal Representative/Relationship to Above Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature on this form acknowledges that I have received a copy of La Crosse County Health Department's Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by La Crosse County Health Department and my rights with respect to my health information.

_____ _____
Patient Signature or Signature of Legal Representative/Relationship to Above Date

Office Use Only:

Office visit _____ Flu _____

❑ MA ❑ MA/HMO ❑ GL Health Plan ❑ Medicare - B ❑ WEA Other_____

ID # _____ Group # _____

❑ Check ❑ Cash ❑ CC Amount _____ Clinic Site _____