CHIPPEWA COUNTY
Public Health

2025-2026 INFLUENZA AND/OR COVID VACCINE ADMINISTRATION RECORD FOR:

Last Name:			First Name:	MI:
Address:			City:	
State:	Zip Code:		Mother's Maiden Name:	
Phone:	DOB:	Age:	Sex Assigned at Birth: Male ☐ Female ☐ Intersex ☐	Race:

Chippewa County Employee Information

Employee ID: _____ Employee Name: _____

Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

☐ Chippewa County Employee Health Insurance Subscriber ID: _____

☐ Chippewa County Employee/State-County Employee/Family Member without county insurance **(Complete next section)**

Fill out this section if you DO NOT have AmeriBen for insurance

☐Medicare ID: _____ ☐ForwardHealth (Medicaid) ID: _____

☐Other Insurance Company Name: _____

Address: _____

City: _____State: _____ Zip Code: _____

Subscriber Name: _____ Subscriber DOB: _____

Subscriber ID: _____ Group ID: _____

☐ Personal Pay (Due at time of service): ☐ **Flu -$55.00** ☐ **COVID-19 -$195.00**

I have read or have had explained to me the information about influenza and influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the influenza vaccine and ask that the vaccine be given to me or the person named below for whom I am authorized to make this request.

Information collected on this form will be used to document authorization for receipt of vaccine(s). Information may be shared through the Wisconsin Immunization Registry (WIR) with other healthcare providers directly involved with the vaccine recipient to assure completion of the vaccine schedule.

My signature on this form acknowledges that I have been offered a copy of Chippewa County Department of Public Health'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 Chippewa County Department of Public Health and an explanation of my rights with respect to my health information.

We accept most insurance plans; however, you will be responsible for the cost if your insurance denies coverage.

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

X _____ Date: _____

********** (OFFICE USE ONLY) **********

VACCINE	ROUTE	IM SITE ADMIN	MANUFACTURER	LOT NUMBER	EXPIRATION DATE	SIGNATURE OF VACCINE ADMIN
COVID-19	IM	RV LV RD LD	Pfizer			
INFLUENZA	IM / Nasal	RV LV RD LD	ID Biomedical-GSK			

Date of Administration: _____Clinic Location: _____

WIR _____ Billing _____ Completed _____

Chippewa County Department of Public Health 711 N. Bridge St, Room 121, Chippewa Falls, WI 54729