Vaccine Administration Record

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 health care providers directly involved with the patient to assure completion of the vaccine schedule. Information collected on this form is voluntary and the Social Security number will be used by parent or guardian to access the Wisconsin Immunization Registry.

Chart number

Patient's name (last, first, middle initial) include maiden name if married			Mother's maiden name (last, first, middle initial)		
Address	P.O. box	City	County	State	ZIP code
Email address (if applicable)	Home phone number ( )		Work phone number (include extension number) ( )		
Social Security number	Date of birth (mm/dd/yyyy)	Patient birth state/country	Gender ☐ Male ☐ Female		
Race (check one) ☐ African American ☐ American Indian or Alaskan Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other			Ethnicity (check one) ☐ Hispanic or Latino ☐ Non-Hispanic or Latino		

Eligibility status (check all that apply)
This section must be completed.

☐ **American Indian/Alaska Native** ☐ **Medicaid eligible** ☐ **BadgerCare** ☐ **No health insurance** ☐ **Insured, vaccines covered** ☐ **Insured, vaccines not covered**

Name of physician	Name of insurance provider	Name of school or day care (if applicable)
Name of parent or guardian responsible for patient (last, first, middle initial)		Relationship to patient
Is reminder or recall contact allowed? ☐ Yes ☐ No		Would you like reminder/recall sent to you? ☐ Yes ☐ No

I have been given a copy of the most recent Vaccine Information Statement (VIS) 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.
Wisconsin Medicaid restricts billing recipients for any covered service(s). I understand that if I am a Medicaid/BadgerCare recipient I cannot be charged an administration fee or asked for any type of donation for the administration of any vaccine that is being provided.

I give permission to share my child's immunization records including those provided to School(s) with the Wisconsin Immunization Registry and my Immunization Provider for the purpose of maintaining a complete and accurate record to assist in assuring full immunization.
Check here **only** if you do **not** give your permission ☐.

Signature - Person to receive vaccine or person authorized to sign on the patient's behalf	Date signed
X	

Patient's name (last, first, middle initial)

Vaccine	Route	Site admin.*	Manufacturer	Vaccine trade name	Lot number	VIS publication date
COVID-19	IM	RV LV RD LD				
DTaP	IM	RV LV RD LD				
Hep A	IM	RV LV RD LD				
Hep B	IM	RV LV RD LD				
Hib	IM	RV LV RD LD				
HPV	IM	RV LV RD LD				
Influenza	IN**					
	IM	RV LV RD LD				
Meningococcal	IM	RV LV RD LD				
MMR	IM or SC§	RV LV RD LD				
Mpox	SC	RV LV RD LD				
	ID					
Pneumococcal	IM	RV LV RD LD				
Polio	IM or SC	RV LV RD LD				
Rotavirus	Oral					
RSV (vaccine)	IM	RV LV RD LD				
RSV (mAb)	IM	RV LV RD LD				
Td	IM	RV LV RD LD				
Pertussis/Tdap	IM	RV LV RD LD				
Varicella	IM or SC	RV LV RD LD				
Zoster (RZV)	IM	RV LV RD LD				
Other						
Other						

***RV=right vastus lateralis, LV=left vastus lateralis, RD=right deltoid, LD=left deltoid, IM=intramuscular, SC=subcut (subcutaneous), ID=intradermal**

****IN=Intranasal §Priorix (MMR) can only be given SC**

Signature and title – Person administering vaccine

X

Date vaccine administered

Address – clinic, public health department