

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 Telephone Number ()			Work Telephone Number (Include extension number) ()					
Social Security Number			Date of Birth (mm/dd/yyyy)		Patient Birth State/Country			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female			
Race (Check one) <input type="checkbox"/> African American <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian / Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other						Ethnicity (Check one) <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino					
Eligibility Status (Check all that apply)		<input type="checkbox"/> Native American		<input type="checkbox"/> Badger Care		<input type="checkbox"/> Insured, Vaccines Covered					
This section must be completed.		<input type="checkbox"/> Medicaid Eligible		<input type="checkbox"/> No Health Insurance		<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No					Would you like reminder/recall sent to you? <input type="checkbox"/> Yes <input type="checkbox"/> No						
<p>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.</p> <p>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.</p> <p>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 <input type="checkbox"/>.</p>											
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)

FOR OFFICE USE

Vaccine	Route	Site Admin.*	Dose Number	Manufacturer	Lot Number	VIS Form Date ☼ (fill in VIS date)
DTaP	IM	RV LV RD LD	1 2 3 4 5			
DTaP-Hep B-IPV (Pediatrix)	IM	RV LV RD LD	1 2 3	GSK		
DTaP-IPV (Kinrix)	IM	RV LV RD LD	1	GSK		
DTaP-IPV-Hib (Pentacel)	IM	RV LV RD LD	1 2 3 4	Sanofi		
Hep A	IM	RV LV RD LD	1 2			
Hep B	IM	RV LV RD LD	1 2 3 4			
Hep A-Hep B (Twinrix)	IM	RV LV RD LD	1 2 3	GSK		
Hib	IM	RV LV RD LD	1 2 3 4			
Hib-Hep B (Comvax)	IM	RV LV RD LD	1 2 3	Merck		
HPV (Human papillomavirus)	IM	RV LV RD LD	1 2 3	Merck		
Influenza	IN**		1 2			
	IM	RV LV RD LD	1 2			
Meningococcal Conjugate (MCV4)	IM	RV LV RD LD	1	Sanofi		
MMR	SQ	RV LV RD LD	1 2	Merck		
Pneumococcal Conjugate (PCV13)	IM	RV LV RD LD	1 2 3 4	Wyeth		
Polio	IM or SQ	RV LV RD LD	1 2 3 4	Sanofi		
Rotavirus	Oral		1 2 3			
Td	IM	RV LV RD LD	1 2 3			
Tdap	IM	RV LV RD LD	1			
Varicella	SQ	RV LV RD LD	1 2	Merck		
Other						

*RV=R Vastus Lateralis, LV=L Vastus Lateralis, RD=R Deltoid, LD=L Deltoid Subcutaneous injections are administered in the muscle "area". **IN = Intranasal
 ☼ Use most current Vaccine Information Statement (VIS) or if appropriate use the Multi Vaccines Information Statement (VIS). For Td & Tdap use the combination Td/Tdap VIS

SIGNATURE AND TITLE – Person Administering Vaccine
 X

Date Vaccine Administered

Address – Clinic, Public Health Department