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.

Patient's Name (Last, First, Middle Initial)	(Include maiden name/other name)	Mother's Maiden Name (Last, First, Middle Initial)

Address (Street/Road/POBox/Apt #)	Telephone Number ( )

City	County	State	Zip Code	Email address:	Patient Birth State/Country

Social Security Number	Date of Birth (mm/dd/yyyy)	Gender	Ethnicity (Check one)
	/ /	☐ Male ☐ Female	☐ Hispanic ☐ Non-Hispanic or Latino

Race (Check one)
☐ African American ☐ American Indian or Alaskan Native ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other

Name of School (if applicable)

Eligibility Status
(Check all that apply)
This section must be completed.

☐ **Native American** ☐ **Badger Care** ☐ **Insured, Vaccines Covered**
☐ **Medicaid Eligible** ☐ **No Health Insurance** ☐ **Insured, Vaccines Not Covered**

Name of Physician/Clinic	Name of Insurance Provider	Is reminder or recall contact allowed? ☐ Yes ☐ No
Name of Parent or Guardian Responsible for Patient (Last, First, Middle Initial)	Relationship to Patient	Would you like reminder/recall sent to you? ☐ Yes ☐ No

I have been given a copy of Vaccine Information Statements (VIS) of vaccines to be given 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 ☐

X SIGNATURE - Person to receive vaccine or person authorized to sign on the patient's behalf.	Date Signed

FOR OFFICE USE

* RV=R Vastus Lateralis, LV=L Vastus Lateralis, RD=R Deltoid, LD=L Subcutaneous injections are administered in the muscle "area".

Vaccine	Route	Site Admin*	Dose Number	Manufacturer	Lot Number	Exp Date	CDC Form Date	VIS Taken
◯ DTaP (Infanrix)	IM	RV LV RD LD	1 2 3 4 5	GSK			08/06/21*	Y N
◯ DTaP- IPV Combined (Kinrix)	IM	RV LV RD LD	1 2 3 4	GSK			Use dates from DTaP, Polio	Y N
◯ DTaP-HepB-IPV-HIB Combined (Vaxelis)	IM	RV LV RD LD	1 2 3 4	GSK			Use dates from DTaP, HepB, Polio	Y N
◯ Hepatitis A	IM	RV LV RD LD	1 2	GSK			10/15/21	Y N
◯ Hepatitis B	IM	RV LV RD LD	1 2 3	GSK			05/12/23	Y N
◯ Hib	IM	RV LV RD LD	1 2 3 4	SP			08/06/21*	Y N
◯ HPV (Gardasil 7) (Human Papillomavirus)	IM	RV LV RD LD	1 2 3	Merck			08/06/21	Y N
◯ Men ACWY (MenQuadfi)	IM	RV LV RD LD	1 2	SP			08/06/21	Y N
◯ Men B (Bexsero)	IM	RV LV RD LD	1 2	GSK				
◯ MMR	SQ	RV LV RD LD	1 2	Merck			08/06/21	Y N
◯ MMRV (MMR - Varicella)	SQ	RV LV RD LD	1 2	Merck			08/06/21	Y N
◯ Pneumococcal Conjugate (PCV13) (Prevnar 13)	IM	RV LV RD LD	1 2 3 4	Wyeth			05/12/23*	Y N
◯ Polio (IPV)	IM or SQ	RV LV RD LD	1 2 3 4	SP			08/06/21	Y N
◯ Rotavirus	Oral	Oral	1 2 3	Merck			10/15/21*	Y N
◯ Td	IM	RV LV RD LD	1 2 3 4 5	SP			08/06/21	Y N
◯ Tdap (Boostrix)	IM	RV LV RD LD	1	GSK			08/06/21	Y N
◯ Varicella (Chickenpox)	SQ	RV LV RD LD	1 2	Merck			08/06/21	Y N
◯ Other		RV LV RD LD	1 2 3 4					Y N

Signature & Title - Person Administering Vaccine		Date Vaccine Administered	BILL TO:	* MultiVaccine ◯ Form Used 10/15/21
Staff Nurse	RN BSN	/ /		

Public Health
Prevent. Promote. Protect

Screening Questionnaire for Immunizations

FOR PATIENTS / PARENTS / GUARDIANS: The following questions will help us determine which vaccines may be given today. If a question is not clear, please ask the nurse to explain it.

Don't Know	YES	NO	Fill out form about person receiving shots listed on the other side of this form.
☐	☐	☐	1. Is the person sick today?
☐	☐	☐	2. Does the person have allergies to medications, food, or any vaccine?
☐	☐	☐	3. Has the person had a serious reaction to a vaccine in the past?
☐	☐	☐	4. Has the person had a seizure or a brain problem?
☐	☐	☐	5. Does the person have cancer, leukemia, AIDS, or any other immune system problem?
☐	☐	☐	6. Has the person taken cortisone, prednisone, other steroids, or anti-cancer drugs, or had x-ray treatments in the past 3 months?
☐	☐	☐	7. Has the person received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin in the past year?
☐	☐	☐	8. Has the person received any vaccinations in the past 4 weeks?
☐	☐	☐	FOR WOMEN ONLY: Is the person pregnant or is there a chance she could become pregnant in the next 3 months?

I acknowledge that I have received a copy of the Grant County Health Department's Notice of Privacy Practice and have been given an opportunity to discuss concerns. I consent to have my protected health information used for treatment, payment and health care operations.

SIGNATURE: _____ Date: _____
(Person to receive vaccine or person authorized to sign on the patient's behalf.)