

Grant County Health Department: Vaccine Administration Record and Screening

Information collected on this form will be used to document authorization for receipt of vaccines. The information will 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 confidential.

HEALTH DEPARTMENT First Las	st M Nev	v Patient					
Date of Birth:/ Gender: Male Female Other Mother's Maiden Name: Address: Zip: Telephone: Member Number							
	ocial Security Num	ber:					
Questions for person receiving vaccine							
1. Are you sick today? (fever, cough, shortness of breath, nausea/vomiting in the last 24 hours, or in your COVID infection isolation period?)							
2. Do you have allergies to medications, food, a vaccine ingredient, or latex?							
. Have you ever had a serious reaction after receiving a vaccine?							
4. Do you have a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood clotting disorder, no spleen, component deficiency, a cochlear implant, or a spinal fluid leak?	, complement						
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?							
6. Have you had a seizure or a brain or other nervous system problem?							
7. Have you received any vaccinations in the past 4 weeks?							
In the past 3 months, have you taken medicines that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?							
During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?							
10. Women: Are you pregnant or is there a chance you could become pregnant during the next month?							
*If you answered YES to any of these questions, you may not receive your vaccination today. I have been given a copy and have read, or have had explained to me, the Vaccine Fact Sheet for recipients and caregivers. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefit to receive the vaccine in a public location. I understand the benefits and risks of the vaccine requested and ask that the vaccine be given to me. I give permission to share my child's immunization records including those provide Immunization Registry and my immunization provider for the purpose of maintaining a complete and accurate record to assist in assuring full immunization. Y N							
Signature- Person to receive vaccine or person authorized to sign on the patient's behalf.							
X Date: Date:	nder/recall sent to yo	u?					

 $\label{eq:minor} \textbf{Minor (under age 18) receiving vaccine: } \textbf{MUST have consent from parent or legal guardian.}$

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Vaccine	Route	Site Admin*	Dose Number	Manufacturer	Lot Number	VIS Date
COVID-19	IM	RV LV RD LD	1 2 3 4 5	Moderna (2024-2025)		3/31/2025
DTP/aP (Dtap)	IM	RV LV RD LD	1 2 3 4 5	Infanrix - GSK		8/6/2021
DTP/aP (Dtap-IPV)	IM	RV LV RD LD	1	Kinrix - GSK		8/6/2021
DTP/aP (Dtap-IPV-Hep B-HIB)	IM	RV LV RD LD	1 2 3	Vaxelis - GSK		8/6/2021
Нер А	IM	RV LV RD LD	1 2	Havrix - GSK		1/31/2025
Нер В	IM	RV LV RD LD	1 2 3	Recombivax - Merk		1/31/2025
Hib	IM	RV LV RD LD	1 2 3 4	ActHIB – Sanofi		8/6/2021
HPV	IM	RV LV RD LD	1 2 3	Gardasil 9- Merck		8/6/2021
Influenza	IM	RV LV RD LD	1 2	Fluzone or FluMist		1/31/2025
Meningococcal or Men B	IM	RV LV RD LD	1 2	MenQuadfi –Bexsero Sanofi Pasteur		1/31/2025
MMR	IM or SQ	RV LV RD LD	1 2	MMRII - Merck		1/31/2025
MMRV	IM or SQ	RV LV RD LD	1 2	ProQuad - Merck		1/31/2025
Pertussis/Tdap	IM	RV LV RD LD	1	Boostrix- GSK		1/31/2025
Pneumococcal (PCV 15)	IM	RV LV RD LD	1 234	Vaxneuvance- Merk		5/29/2025
Polio	IM or SQ	RV LV RD LD	1 2 3 4	IPOL- Sanofi Pasteur		1/31/2025
Rotavirus	Oral	Oral	1 2 3	RotaTeq- Merck		10/15/2021
RSV (Less than 11 Pounds) 50MG	IM	RV LV RD LD	1	Beyfortus- Sanofi Pasteur		9/25/2023
RSV (11 pounds or more) 100MG	IM	RV LV RD LD	1	Beyfortus- Sanofi Pasteur		9/25/2023
Varicella	IM or SQ	RV LV RD LD	1 2	Varivax - Merck		1/31/2025
COVID-19 ADULT	IM	RV LV RD LD	1 2 3 4 5	Spikevax (23-24)		1/31/2025
Hep A- ADULT - Private	IM	RV LV RD LD	1 2	Havrix- GSK		1/31/2025
HEP B- ADULT- Private	IM	RV LV RD LD	1 2 3	Engerix B - GSK		1/31/2025
Hep A- ADULT - VFA	IM	RV LV RD LD	1 2	Havrix - GSK		1/31/2025
HEP B – ADULT- VFA	IM	RV LV RD LD	1 2 3	Heplisav-B Dynavax		1/31/2025
HPV- ADULT - VFA	IM	RV LV RD LD	1 2 3	Gardasil 9- Merck		8/6/2021
Influenza- ADULT	IM	RV LV RD LD	1	FluLaval, Fluzone High Dose		1/31/2025
MMR- ADULT – VFA	SQ	RV LV RD LD	1 2	MMR- Merck		1/31/2025
TDAP- ADULT – VFA	IM	RV LV RD LD	1 2	Boostrix- GSK		1/31/2025

*RV = R Vastus Lateralis, LV = L Vastus Lateralis, RD = R Deltoid, LD = L Deltoid SQ=Subcutaneous

SIGNATURE/TITLE OF PERSON(S) ADMINISTERING VACCINE

Date Vaccine Administered

Date Vaccine Administered

Date Vaccine Information Statements Presented