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 ☐ Male ☐ Female | Ethnicity (Check one) ☐ 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			08/24/18 *	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 Combined (Pediarix)	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			7/20/16	Y N
◯ Hepatitis B	IM	RV LV RD LD	1 2 3	GSK			8/15/19*	Y N
◯ Hib	IM	RV LV RD LD	1 2 3 4	SP			10/30/19 *	Y N
◯ HPV (Gardasil 7) (Human Papillomavirus)	IM	RV LV RD LD	1 2 3	Merck			10/30/19	Y N
◯ Men ACWY (Menactra) ◯ Men B (Bexsero)	IM IM	RV LV RD LD RV LV RD LD	1 2 1 2	SP GSK			8/15/19	Y N
◯ MMR	SQ	RV LV RD LD	1 2	Merck			8/15/19	Y N
◯ MMRV (MMR - Varicella)	SQ	RV LV RD LD	1 2	Merck			8/15/19	Y N
◯ Pneumococcal Conjugate (PCV13) (Prevnar 13)	IM	RV LV RD LD	1 2 3 4	Wyeth			10/30/19 *	Y N
◯ Polio (IPV)	IM or SQ	RV LV RD LD	1 2 3 4	SP			7/20/16*	Y N
◯ Rotavirus	Oral	Oral	1 2 3	Merck			10/30/19 *	Y N
◯ Td	IM	RV LV RD LD	1 2 3 4 5	SP			4/11/17	Y N
◯ Tdap (Boostrix)	IM	RV LV RD LD	1	GSK			2/24/15	Y N
◯ Varicella (Chickenpox)	SQ	RV LV RD LD	1 2	Merck			8/15/19	Y N
◯ Other		RV LV RD LD	1 2 3 4					Y N

Signature & Title - Person Administering Vaccine Staff Nurse RN BSN | **Date Vaccine Administered** | BILL TO:

◯ * MultiVaccine Form Used 11/5/15