

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)				Telephone Number ()	
City	County	State	Zip Code	Email address:	Patient Birth State/Country
Social Security Number		Date of Birth (mm/dd/yyyy)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Ethnicity (Check one) <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic or Latino
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 or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other				Name of School (if applicable)	

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

<input type="checkbox"/> Native American	<input type="checkbox"/> Badger Care	<input type="checkbox"/> Insured, Vaccines Covered
<input type="checkbox"/> Medicaid Eligible	<input type="checkbox"/> No Health Insurance	<input type="checkbox"/> Insured, Vaccines Not Covered

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

-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.

-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
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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 Dat
DTaP (Infanrix)	IM	RV LV RD LD	1 2 3 4 5	GSK			05/17/07 *
DTaP-IPV Combined (Kinrix)	IM	RV LV RD LD	1 2 3 4	GSK			Use dates from DTaP, Polio
DTaP-HepB-IPV Combined (Pediatrix)	IM	RV LV RD LD	1 2 3 4	GSK			Use dates from DTaP, HepB, Polio
Hepatitis A	IM	RV LV RD LD	1 2	GSK			10/25/11
Hepatitis B	IM	RV LV RD LD	1 2 3	GSK			2/2/12*
Hib	IM	RV LV RD LD	1 2 3 4	SP			4/2/15 *
HPV (Gardasil / Gardasil 7) (Human Papillomavirus)	IM	RV LV RD LD	1 2 3	Merck			5/17/13
Meningococcal Conjugate (MVC4)	IM	RV LV RD LD	1	SP			10/14/11
MMR	SQ	RV LV RD LD	1 2	Merck			4/20/12
MMRV (MMR & Varicella)	SQ	RV LV RD LD	1 2	Merck			5/21/10
Pneumococcal Conjugate (PCV13) (Prevnar)	IM	RV LV RD LD	1 2 3 4	Wyeth			2/27/13 *
Polio	IM or SQ	RV LV RD LD	1 2 3 4	SP			11/8/11 *
Rotavirus	Oral	Oral	1 2 3	Merck			4/15/15 *
Td (Tenivac)	IM	RV LV RD LD	1 2 3 4 5	SP			2/24/15
Tdap (Boostrix)	IM	RV LV RD LD	1	GSK			2/24/15
Varicella (Chickenpox)	SQ	RV LV RD LD	1 2	Merck			3/13/08
Other		RV LV RD LD	1 2 3 4				

Signature & Title - Person Administering Vaccine Staff Nurse	RN BSN	Date Vaccine Administered	MultiVaccine Form Used 10/22/2014
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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.)