Shawano County Health Department

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)	**Mother's Maiden Name** (Last, First, Middle Initial)

Address	**P. O. Box**

City	**State**	**Zip Code**	**Date of Birth**	**Age**	☐ **Male** ☐ **Female**

Primary Phone Number ( )	**E-mail Address:**	**Social Security Number**

Race (Check one)	☐**African American** ☐**Asian** ☐**Caucasian** ☐**Native American** ☐ **Other**	**Ethnicity** (Check one) ☐ **Hispanic** ☐ **Non-Hispanic**
Eligibility Status (Check all that apply)	☐ **Native American** ☐ **No Health Insurance** ☐ **BadgerCare**	☐ **Insured**, Vaccines Covered ☐ **Insured**, Vaccines Not Covered

Name of Parent or Guardian Responsible for Patient (Last, First, Middle Initial)	**Relationship to Patient**

Okay to share immunization data with WIR? (Wisconsin Immunization Registry) ☐ **Yes** ☐ **No**
Is reminder or recall contact allowed? ☐ **Yes** ☐ **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. I acknowledge I have been made aware that the *Notice of Privacy Practices Regarding Health Information* is available at the Shawano County Health Department's website and onsite. I have been given an opportunity to discuss my concerns and questions.

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.

SIGNATURE (Person to receive vaccine or person authorized to sign on the patient's behalf)	**Date Signed**

(This form has been modified from DHFS Form #4702)

PLEASE ANSWER……..Screening Questions For Immunizations

The following questions will help us determine which vaccines you or your child may be given today. If you answer "yes" to any question, it does not necessarily mean you or your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask you're the nurse to explain it.	Yes	No	Don't Know
1. Is the person receiving immunizations sick today?			
2. Does the person have allergies to medications, food, or any vaccine?			
3. Has the person had a severe allergic reaction to latex?			
4. Has the person had a serious reaction to a vaccine in the past?			
5. Has the person had a seizure, brain, or nerve problem?			
6. Does the person have cancer, leukemia, AIDS, or any other immune system problem?			
7. Has the person taken cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments in the past 3 months?			
8. Has the person received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin the past year?			
9. Is the person pregnant or is there a chance she could become pregnant during the next three months?			
10. Has the person received vaccinations in the past 4 weeks?			
11. In the past 12 months, has a healthcare provider ever told you that your child has wheezing or asthma? (for children less than 5 years old)			
12. Has the person had a health problem with lung, heart, kidney or metabolic disease (e.g. diabetes), asthma, or a blood disorder? Is the person on long-term aspirin therapy?			

FOR OFFICE USE ONLY

Vaccine	CPT	Route	Site Admin.*	Dose Number	Lot Number	CDC Form Date / Vaccine Manufacturer
DTaP	90700	IM	RV LV RD LD	1 2 3 4 5		05/17/07 / GlaxoSmithKline
DTaP-HIB-IPV (Pentacel)	90698	IM	RV LV RD LD	1 2 3 4		Use VIS-DTaP, HIB, IPV / Sanofi Pasteur
DTaP-Polio (Kinrix)	90696	IM	RV LV RD LD	1		Use VIS-DTaP, IPV / GlaxoSmithKline
HPV	90649	IM	RV LV RD LD	1 2 3		05/03/11 / Merck & Co
Hep A	90633	IM	RV LV RD LD	1 2		10/25/11 / GlaxoSmithKline
Hep B	90744	IM	RV LV RD LD	1 2 3		07/18/07 / GlaxoSmithKline
Hib	90648	IM	RV LV RD LD	1 2 3 4		12/16/98 / Merck & Co
MMR	90707	SQ	RL LL RA LA	1 2		03/13/08 / Merck & Co
Meningococcal	90734	IM	RV LV RD LD	1 2		10/14/11 / Sanofi Pasteur
Pneumococcal Conjugate (PCV13)	90670	IM	RV LV RD LD	1 2 3 4 5		04/16/10 / Wyeth Lederle
Polio	90713	IM	RV LV RD LD	1 2 3 4		11/08/11 / Sanofi Pasteur
Rotavirus (Rotateq)	90680	PO		1 2 3		12/06/10 / Merck & Co
Td	90718	IM	RV LV RD LD	1 2 3 4		01/24/12 / Sanofi Pasteur
TdaP - Boostrix	90715	IM	RV LV RD LD	1		01/24/12 / GlaxoSmith Kline
Varicella	90716	SQ	RL LL RA LA	1 2		03/13/08 / Merck & Co

SIGNATURE AND TITLE – Person Administering Vaccine

Date Vaccine Administered

Address

Shawano County Health Department 311 N. Main Street, Room 7 Shawano, WI 54166

Notes:

Circle & Record Refusals in WIR:

DTaP Pentacel Kinrix HPV Hep A Hep B Varicella
MMR MCV4 PCV13 IPV ROTA Td/Tdap Hib

2 Mths	**Pentacel – (DTaP, IPV, HIB) Hep B PCV13 Rotateq**
4 Mths	**Pentacel – (DTaP, IPV, HIB) PCV13 Rotateq Hep B – (If no birth dose was given)**
6 Mths	**Pentacel – (DTaP, IPV, HIB) Hep B – (Minimum age 24 wks) PCV13 Rotateq**
12 Mths	**PCV13 MMR Varicella Hep A**
18 Mths	**Pentacel – (DTaP, IPV, HIB) Hep A – need 6 mo. From Hep A #1 Is Hep B #3 valid?**

☐ **Cash** ☐ **Check** **Receipt #**
☐ **Send Immunization Record to Parent**
☐ **Entered in WIR**
☐ **Claim Sent**
Date:
Amount:
Billed to: