VACCINE ADMINISTRATION RECORD – ADULT (19 years and over)

UNINSURED AND UNDERINSURED*

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 patient to access WIR.

PLEASE PRINT using black or blue ink only

Patient's Legal Name (Last, First, MI) Include maiden name if married.				Mother's Maiden Name (Last, First)
Address	City		County State	Zip Code
Date of Birth	Age	Gender ☐M ☐F	Social Security Number (Required if patient wants on-line record access.)	Telephone Number
Race ☐White ☐Other (specify)			Ethnicity ☐Non-Hispanic ☐Hispanic	
Eligibility Status ☐Uninsured ☐Underinsured ☐Pertussis-containing vaccine (statewide outbreak)				
Name of Clinic or Physician				
Okay to share immunization data with WIR? ☐Yes ☐No (Allows record access for patient or health care provider.)			Is reminder/recall contact allowed? ☐Yes ☐No (Used if any notice about immunizations is sent.)	
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.				
SIGNATURE				Date Signed

**Underinsured adults are those who have health insurance, but the coverage does not include any vaccines, OR whose insurance covers only selected vaccines, OR whose insurance caps vaccine coverage at a certain amount would be eligible after the cap has been met, OR have Badger Care+ Family Planning Only Services.*
Adults with Medicaid coverage are considered insured as they are covered by all ACIP recommended vaccines.

OFFICE USE ONLY Clinic Site: Clintonville Waupaca Other_____

Vaccine	Route	Site Admin.	Dose #	Mfg.	Lot #	Expire Date	CDC Form Date
Hep A	IM	RD LD	1 2				10/25/11
Hep B	IM	RD LD	1 2 3				2/2/12
Hep A – Hep B	IM	RD LD	1 2 3				See Hep A & B
HPV	IM	RD LD	1 2 3				2/22/12
Influenza	IM	RD LD	1 Booster				Use latest VIS
MMR	SQ	RD LD	1 2				4/20/12
Meningococcal	IM	RD LD	1 2				10/14/11
Td	IM	RD LD	1 Booster				1/24/12
Tdap	IM	RD LD	1				1/24/12
Varicella	SQ	RD LD	1 2				3/13/08
SIGNATURE AND TITLE – Person Administering Vaccine						Date Vaccine Administered	

Waupaca County Department of Health and Human Services, Health Services Division, 811 Harding St., Waupaca, WI 54981

ADULT IMMUNIZATION HEALTH SCREENING

(19 years and over)

NAME	DOB	NO	YES	Nurse Use Only Contraindication
1. Are you sick today or do you have a fever?				
2. Do you have allergies to latex, medications, food, or any vaccine?				See 2. Below
3. Have you ever had a serious reaction after receiving a vaccination?				
4. Do you have cancer, leukemia, AIDS, or any other immune system problem?				MMR, Varicella
5. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?				MMR, Varicella
6. Have you had a seizure, brain, or nerve problem?				Td, Tdap, Influenza, MCV4
7. During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?				MMR, Varicella
8. Are you pregnant or is there a chance you could become pregnant during the next month? (answer "No" if male)				MMR, Varicella, Td, Tdap, HPV
9. Have you received any vaccinations in the past 4 weeks?				MMR, Varicella
10. Have you ever had Guillain Barré syndrome (a type of temporary severe muscle weakness)?				Influenza

NURSE USE ONLY 2. Eggs–Influenza Gelatin–MMR, Varicella Neomycin–MMR, Varicella, Hep A Yeast–Hep B, HPV Latex–Tdap

Waupaca County Department of Health and Human Services – HIPAA
Acknowledgement of Receipt of Notice of Privacy Practices Regarding Health Information

By signing this form, you acknowledge that Waupaca County Department of Health and Human Services has given you a copy of its Notice of Privacy Practices Regarding Health Information, which explains how your health information will be handled in various situations. All clients receiving services on or after April 14, 2003, will be asked to sign this form.

If your first date of service with Waupaca County Department of Health and Human Services was due to an emergency, we must try to give you this notice and get your signature acknowledging receipt of this notice as soon as possible after the emergency.

By my signature below, I acknowledge I have received a copy of the Waupaca County Department of Health and Human Services' Notice of Privacy Practices Regarding Health Information and have been given an opportunity to discuss my concerns and questions.

Signature_____ Date_____

NURSE USE ONLY

Reviewed Common Side Effects	Private Pay Hep B
Gave Vaccine Information Sheet(s)	( )cash
Recommended Next Immunizations Due and Date	( )check
WIR Data Entry Completed	( )Bill Employer _____
PHN Initials	Date