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.

CHART NUMBER

Patient's Name (Last, First, Middle Initial) Include maiden name if married.

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

Address | P. O. Box | City | County | State | Zip Code

Email address (If applicable)

Home Telephone Number ( )

Work Telephone Number (Include extension number) ( )

Social Security Number

Date of Birth (mm/dd/yyyy)

Patient Birth State/Country

Gender ☐ Male ☐ Female

Race (Check one)
☐ African American ☐ American Indian or Alaskan Native ☐ Asian ☐ Native Hawaiian / Pacific Islander
☐ White ☐ Other

Ethnicity (Check one)
☐ Hispanic or Latino ☐ Non-Hispanic or Latino

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

Native American
Medicaid Eligible

☐ **Badger Care**
☐ **No Health Insurance**

☐ **Insured, Vaccines Covered**
☐ **Insured, Vaccines Not Covered**

Name of Physician

Name of Insurance Provider

Name of School or Day Care (If applicable)

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

Relationship to Patient

Okay to share immunization data with Wisconsin Immunization Registry (WIR)?
☐ Yes ☐ No

Is reminder or recall contact allowed?
☐ Yes ☐ No

Would you like reminder/recall sent to you?
☐ 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.

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.

X

Date Signed

Patient's Name (Last, First, Middle Initial)

FOR OFFICE USE

Vaccine	Route	Site Admin.*	Dose Number	Manufacturer	Lot Number	VIS Form Date ☼ (fill in VIS date)
DTaP/DT	IM	RV LV RD LD	1 2 3 4 5			
DTaP-Hep B-IPV **(Pediarix)**	IM	RV LV RD LD	1 2 3	GSK		
DTaP-IPV **(Kinrix)**	IM	RV LV RD LD	1	GSK		
DTaP-IPV-Hib **(Pentacel)**	IM	RV LV RD LD	1 2 3 4	Sanofi		
Hep A	IM	RV LV RD LD	1 2			
Hep B	IM	RV LV RD LD	1 2 3 4			
Hep A-Hep B **(Twinrix)**	IM	RV LV RD LD	1 2 3	GSK		
Hib	IM	RV LV RD LD	1 2 3 4			
Hib-Hep B **(Comvax)**	IM	RV LV RD LD	1 2 3	Merck		
HPV (Human papillomavirus)	IM	RV LV RD LD	1 2 3	Merck		
Influenza	IN**		1 2			
	IM	RV LV RD LD	1 2			
Meningococcal Conjugate (MCV4)	IM	RV LV RD LD	1	Sanofi		
MMR	SQ	RV LV RD LD	1 2	Merck		
Pneumococcal Conjugate (PCV7)	IM	RV LV RD LD	1 2 3 4	Wyeth		
Polio	IM or SQ	RV LV RD LD	1 2 3 4	Sanofi		
Rotavirus	Oral		1 2 3			
Td	IM	RV LV RD LD	1 2 3			
Tdap	IM	RV LV RD LD	1			
Varicella	SQ	RV LV RD LD	1 2	Merck		
Other						

***RV=R Vastus Lateralis, LV=L Vastus Lateralis, RD=R Deltoid, LD=L Deltoid Subcutaneous injections are administered in the muscle "area". **IN = Intranasal**
☼ Use most current Vaccine Information Statement (VIS) or if appropriate use the Multi Vaccines Information Statement (VIS). For Td & Tdap use the combination Td/Tdap VIS

SIGNATURE AND TITLE – Person Administering Vaccine **X**	Date Vaccine Administered

Address – Clinic, Public Health Department