

## 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 <input type="checkbox"/> Male <input type="checkbox"/> Female
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 / Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other				Ethnicity (Check one) <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino		
<b>Eligibility Status (Check all that apply)</b> <b>This section must be completed.</b>		<input type="checkbox"/> Native American <input type="checkbox"/> Medicaid Eligible		<input type="checkbox"/> Badger Care <input type="checkbox"/> No Health Insurance		<input type="checkbox"/> Insured, Vaccines Covered <input type="checkbox"/> 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)? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is reminder or recall contact allowed? <input type="checkbox"/> Yes <input type="checkbox"/> No		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.						
<b>Wisconsin Medicaid restricts billing recipients for any covered service(s).</b> 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.						
<b>SIGNATURE</b> - Person to receive vaccine or person authorized to sign on the patient's behalf.  <b>X</b>					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 <b>(Pediatrix)</b>	IM	RV LV RD LD	1 2 3	GSK		
DTaP-IPV <b>(Kinrix)</b>	IM	RV LV RD LD	1	GSK		
DTaP-IPV-Hib <b>(Pentacel)</b>	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 <b>(Twinrix)</b>	IM	RV LV RD LD	1 2 3	GSK		
Hib	IM	RV LV RD LD	1 2 3 4			
Hib-Hep B <b>(Comvax)</b>	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