DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-44702 (Rev. 10/10)
Page 1

STATE OF WISCONSIN
Wis. Stats. 252.04

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

Is reminder or recall contact allowed?	Would you like reminder/recall sent to you?
☐ Yes ☐ No	☐ 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.

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
X	

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	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 (PCV13)	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

IMMUNIZATION SCREENING FORM

Note: The questions apply to the person receiving vaccines today. If a question is not clear, please ask clinic staff to explain it. PLEASE PRINT!

Name: _____ Birthdate:_____
(Last) (First) (MI)

		YES	NO	DON'T KNOW
1.	Are you sick today?	☐	☐	☐
2.	Do you have allergies to medications, to any vaccine, latex, yeast, eggs, gelatin, alum, or any preservatives?	☐	☐	☐
3.	Have you ever had a serious reaction to a vaccine in the past?	☐	☐	☐
4.	Have you ever had a seizure or a history of Guillain-Barré syndrome (GBS)?	☐	☐	☐
5.	Do you, any person who lives with you, (or who has close contact with you), have cancer, leukemia, AIDS, or any other immune system problem?	☐	☐	☐
6.	Have you, or any person who lives with you received cortisone, prednisone, other steroids, anticancer drugs, or x-ray treatments in the past 3 months?	☐	☐	☐
7.	During the past year, have you received a transfusion of blood or plasma, or been given a medicine called immune globulin?	☐	☐	☐
8.	Do you have a long-term health problem such as asthma or other lung disease, heart disease, kidney disease, diabetes, anemia, or other blood disorder?	☐	☐	☐
9.	Have you received any vaccinations in the past 4 weeks?	☐	☐	☐
10.	Have you had chickenpox disease? If yes, when?_____	☐	☐	☐
11.	**For infants 8 weeks to 32 weeks:** Was your child born prematurely?	☐	☐	☐
12.	**For children over 2 years of age:** Has a healthcare provider told you that your child had wheezing or asthma in the past 12 months?	☐	☐	☐
13.	**For children 5 years old:** Does your child suffer from any chronic medical conditions?	☐	☐	☐
14.	**For females age 12 years or older:** Is it possible that you are pregnant or may become pregnant in the next 3 months?	☐	☐	☐

Bring your immunization record every time you come to Public Health or go to the doctor!
Talk to your doctor for suggested frequency of recommended well physical exams.

ADULTS NEED SHOTS TOO! Have you had a tetanus booster in the last 10 years?

I understand Sheboygan County Health and Human Services may bill Forward Health, Medicare or any other 3rd party insurance company for billable services. I have read and completed this screening form to the best of my knowledge and request that the above named person be immunized.

_____ _____
Date Signature (Parent or Legal Guardian's Signature required for persons under 18 years)

_____
Public Health Nurse Reviewing History

Public Health
Prevent. Promote. Protect.

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