



## 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		City	County
P. O. Box		State	Zip Code
Email address (if applicable)		Home Telephone Number ( )	
Social Security Number		Date of Birth (mm/dd/yyyy)	
Work Telephone Number (Include extension number) ( )		Patient Birth State/Country	
Race (Check one)		Gender	
<input type="checkbox"/> African American <input type="checkbox"/> White <input type="checkbox"/> Other		<input type="checkbox"/> Male <input type="checkbox"/> Female	
<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian / Pacific Islander		<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 Parent or Guardian Responsible for Patient (Last, First, Middle Initial)		Name of School or Day Care (if applicable)	
Relationship to Patient		Relationship to Patient	
Okay to share immunization data with Wisconsin Immunization Registry (WIR)? <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.			
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	CDC Form Date
DTaP/DT	IM	RV LV RD LD	1 2 3 4 5			05/17/07
DTaP-Hep B-IPV Combined	IM	RV LV RD LD	1 2 3 4			Use dates from DTaP, Hep B, Polio
Hep A	IM	RV LV RD LD	1 2			03/21/06
Hep B	IM	RV LV RD LD	1 2 3			07/18/07
Hib	IM	RV LV RD LD	1 2 3 4			12/16/98
Hib-Hep B Combined	IM	RV LV RD LD	1 2 3			Use dates from Hib and Hep B
HPV (Human papillomavirus)	IM	RV LV RD LD	1 2 3			02/02/07
Influenza	IN**		1 2			Use latest Vaccine Info. Statement
Meningococcal Conjugate (MCV4)	IM	RV LV RD LD	1 2			01/28/08
MMR	SQ	RV LV RD LD	1 2			03/13/08
MMR-V	SQ	RV LV RD LD	1 2			Use dates from MMR & Varicella
Pneumococcal Conjugate (PCV7)	IM	RV LV RD LD	1 2 3 4			09/30/02
Polio	IM or SQ	RV LV RD LD	1 2 3 4			01/01/00
Rotavirus	Oral		1 2 3			04/12/06 (Interim)
Td	IM	RV LV RD LD	1 2 3 4 5 6			6/10/94
Tdap	IM	RV LV RD LD	1			07/12/06 (Interim)
Varicella	SQ	RV LV RD LD	1 2			03/13/08
DTaP, IPV, Hib, Hep B, PCV7, Rotavirus						Multi Vaccine 01/30/08
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

SIGNATURE AND TITLE -- Person Administering Vaccine

Date Vaccine Administered

Address -- Clinic, Public Health Department

Comments: