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** ☐ **Badger Care** ☐ **Insured, Vaccines Covered**
☐ **Medicaid Eligible** ☐ **No Health Insurance** ☐ **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. | 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

Columbia County Division of Health
2652 Murphy Road
Portage, WI 53901
608-742-9227

Patient Name______________________________________ Date of Birth__________

Screening Questionnaire for Immunizations

For clients or parents/guardians: The following questions will help us determine which vaccines may be given today. If a question is not clear, please ask the nurse to explain it.

	Yes	No	Don't Know
1. Are you/is the child sick today? If yes, please explain: ______________________________	☐	☐	☐
2. Do you/does the child have allergies to latex, medications including preservatives (phenol, formaldehyde, thimerosal, gentamicin, streptomycin, neomycin or arginine) vaccine or food (including egg or chicken protein, gelatin, or yeast)? If yes, please describe: ______________________________	☐	☐	☐
3. Have you/has the child had a serious reaction to a vaccine in the past? If yes, please describe: ______________________________	☐	☐	☐
4. Have you/has the child had a seizure, a brain problem, or a nerve problem, including Guillain-Barré syndrome? If yes, please describe: ______________________________	☐	☐	☐
5. Do you/does the child have cancer, leukemia, AIDS, or any other immune system problem? If yes, please list: ______________________________	☐	☐	☐
6. Have you/has the child taken high-dose steroids, anticancer drugs, or had radiation treatments in the past 3 months? Is your child or teen receiving aspirin therapy or aspirin-containing therapy? If yes, please explain: ______________________________	☐	☐	☐
7. Have you/has the child received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin or an antiviral drug (such as for H1N1) in the past year? If yes, please describe: ______________________________	☐	☐	☐
8. For WOMEN: Are you/is the child/teen pregnant or is there a chance she could become pregnant during the next month?	☐	☐	☐
9. Have you/has the child received any vaccinations in the past 4 weeks? If yes, please list: ______________________________	☐	☐	☐
10. Do you/does the child have a health problem with asthma, lung disease, heart disease, kidney disease, metabolic disease (e.g. diabetes), liver disease, neurologic or neuromuscular disease, anemia, or other blood disorder? Does s/he have a digestive system problem?	☐	☐	☐
11. If your child to be vaccinated is between the ages of 2 and 4, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	☐	☐	☐
12. Does the person to be vaccinated live with or expect to have close contact with a hospitalized person whose immune system is severely compromised and who must be in protective isolation?	☐	☐	☐

Form completed by: ______________________________ Date: ________

You must provide your child's immunization record card.

A Vaccine Information Statement (VIS) is a one-page (two-sided) information sheet, produced by CDC. VISs inform vaccine recipients — or their parents or legal representatives — about the benefits and risks of a vaccine. The law requires that VISs given out whenever certain vaccinations are given. They are updated periodically. This is page documents that the most current version of the form is given to vaccine recipients, parents or legal representatives.

Current Vaccine Information Sheet Dates as of December 2011	
Chicken Pox	03/13/08
DTaP/DT/DTP	05/17/07
Hepatitis A	10/25/11
Hepatitis B	7/18/07
Hib	12/16/98
HPV	05/03/11
Influenza (LAIV)	07/26/11
Influenza (TIV)	07/26/11
Meningococcal	10/14/11
MMR	3/13/08
Multi-vaccine	9/18/08
PCV (Prevnar)	4/16/10
PPSV (Pneumovax)	10/06/09
Polio	11/08/11
Rotavirus	12/06/10
Shingles	10/06/09
Td/Tdap	11/18/08