Columbia County Division of Health
P.O. Box 136
111 E. Mullett St.
Portage, WI 53901-2325

Amish By appt. County Empl

Jail SVDP

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? ☐ 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.

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

Columbia County Division of Health
111 E Mullett ST
Portage, WI 53901
608-742-9227

Patient Name_____ Date of Birth_____

Screening Questionnaire for Immunizations

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.

ANSWER THE QUESTIONS BELOW ***FOR THE PERSON TO RECEIVE THE VACCINE***	Yes	No	Unsure
1. Are you sick today? If yes, please explain: _____	☐	☐	☐
2. Do you have allergies to latex, medications, food (including egg or egg protein, gelatin, or yeast), or any vaccine components? If yes, please describe: _____	☐	☐	☐
3. Have you had a serious reaction to a vaccine in the past? If yes, please describe: _____	☐	☐	☐
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia, or other blood disorder, no spleen, complement component deficiency, cochlear implant, or spinal fluid leak? If yes, please describe: _____	☐	☐	☐
5. Have you, a sibling or a parent had a seizure? Have you had a brain problem, or a nervous system problem, including Guillain-Barré syndrome? If yes, please describe: _____	☐	☐	☐
6. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? Do you have a parent, brother, or sister with an immune system problem? If yes, please list: _____	☐	☐	☐
7. In the past 3 months, have you taken medication that weakens the immune system such high-dose steroids (ex. cortisone or prednisone), anticancer drugs, drugs for the treatment of rheumatoid arthritis, Crohn's disease, psoriasis; or had radiation treatments? If yes, please explain: _____	☐	☐	☐
8. In the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin or an antiviral drug? If yes, please describe: _____	☐	☐	☐
9. For WOMEN and GIRLS: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
10. Have you received any vaccinations in the past 4 weeks? Will you have a TB skin test in the next 4 weeks? If yes, please list what and when: _____	☐	☐	☐
11. For FluMist only (can only be given to people ages 2 through 49): • If the child to be vaccinated is between 2 and 4 years old, in the past 12 months, has a healthcare provider told you that the child had wheezing or asthma? • If the person is between 2 and 17, are they receiving aspirin therapy or aspirin-containing therapy? • Is the person receiving the FluMist receiving antiviral medications? • Does the person live with or expect to have close contact with a person whose immune system is severely compromised and must be in protective isolation?	☐	☐	☐
12. If your child to be vaccinated is a baby, have you ever been told that the baby has had intussusception?	☐	☐	☐
13. ***For adults 19 and older***: If you are female, is your weight greater than 200 lbs.? If you are male, is your weight greater than 260 lbs.? *(this helps us determine the proper needle length to use in order to reach the muscle)*	☐	☐	☐

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 October 2020

Vaccine	Date VIS Given	Current VIS Date	Vaccine	Date VIS Given	Current VIS Date
Chicken Pox		08/15/19	MMR		08/15/19
DTaP		04/01/20	Multi-vaccine		04/01/20
Hepatitis A		07/28/20	PCV13 (Prevnar)		10/30/19
Hepatitis B		08/15/19	PPSV (Pneumovax)		10/30/19
Hib		10/30/19	Polio		10/30/19
HPV Gardasil 9		10/30/19	Rotavirus		10/30/19
Influenza (LAIV)		08/15/19	Td		04/01/20
Influenza (IIV)		08/15/19	Tdap		04/01/20
MenACWY		08/15/19	Zoster		10/30/19
Men B		08/15/19			

Authorization to bill Medicaid/Insurance

I hereby authorize Columbia County Health and Human Services to release any medical information necessary to process my Medicaid/Insurance claims. I further authorize payment of any health insurance policy benefits, including Medicare, Medicaid, private insurance and any other health plan, directly to Columbia County Health and Human Services.

I understand that if Medicaid / Medicare is billed, charges for services will be considered paid in full and I will not be responsible for any difference in the billed amount and the reimbursed amount.

I understand that if private insurance is billed, that I will be financially responsible for any charges not covered by my health insurance, not to exceed my ability to pay requirements.

This authorization applies to any health insurance policy in effect at the time services were provided. A copy of this authorization will be used in place of the original. This authorization is in force until it is either cancelled or changed by me.

Medicaid/Medicare _____ Yes _____ No Number _____ SS# _____

Name of Insurance Provider _____ Billing Address _____ Policy Number _____ Effective Dates _____

_____ _____

Client Signature **Date**

_____ _____

Parent Signature (if applicable) **Date**

Private-pay Billing-for office use only:

Name _____ DOB: _____

Date of Service _____ Name of billable vaccine given: _____

Bill to: _____ Amount: _____

Date submitted to accounting: _____ OR Pd _____ Cash or Check # _____

Employee Flu Vaccine Billing- for office use only

Policy Holder Name: _____ DOB: _____

Name of person vaccinated: _____

DOB of person vaccinated: _____

Date vaccinated: _____

Group # _____

Member# _____