

# VACCINE(S) ADMINISTRATION RECORD

Agency (for office use)

**INFORMATION ABOUT THE PERSON TO RECEIVE VACCINE (PLEASE PRINT)**

ID \_\_\_\_\_

Check all that apply  No Health Insurance  Medicaid Eligible  Insured, Vaccines Not Covered  
 Native American  Insured, Vacc Covered  Badger Care Age: \_\_\_\_\_

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ M. I.: \_\_\_\_\_ Birthdate mm/dd/yy: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Mothers Maiden Name: \_\_\_\_\_ Gender: \_\_\_\_\_ Race: \_\_\_\_\_ Hispanic: \_\_\_\_\_ Telephone: \_\_\_\_\_

Childs Social Security No.: \_\_\_\_\_ Parent/Guardian: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Okay to share data with WIR?  Yes  No Physician: \_\_\_\_\_

**THE PERSON RECEIVING VACCINE TODAY:** (Rev 09/25/2006)

1. Sick or had a fever in the last 24 hours?.....Yes  No
2. Allergic to yeast, gelatin, neomycin, streptomycin or previous vaccines?.....Yes  No
3. Have a history of serious problems with previous immunizations?.....Yes  No
4. Receiving treatment for seizure or neurological problem?.....Yes  No
5. Taking steroids or anti-cancer drugs?.....Yes  No
- Living with any person receiving steroids or anti-cancer drugs?.....Yes  No
6. Received any blood/blood products or immune globulin in the past year?.....Yes  No
7. Received vaccinations or TB skin test in last 2 months?.....Yes  No
8. Had the chicken pox virus?....Date \_\_\_\_\_.....Yes  No
9. Currently pregnant or planning a pregnancy in the next 3 months?.....Yes  No
10. Mother of child is Hepatitis B positive?.....Yes  No
11. Birth weight less than 4 pounds 7 ounces?.....Yes  No
12. Have a history of latex allergy?.....Yes  No
13. Have a history of Guillain-Barre Syndrome?.....Yes  No

**PLEASE READ BEFORE SIGNING**

Information collected on this form will be used to document authorization for receipt of vaccines(s). Information may be shared through the Wisconsin Immunization Registry (WIR) and/or with other health care providers directly involved with the patient to assure completion of the vaccine schedule. Information collected on this form is voluntary. The Social Security Number will be used by the parent or guardian to access the WIR.

I have been given a copy and have read or received explanation regarding 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. I request the vaccine(s) be given to me or to the person named below for whom I am authorized to make this request.

PLEASE PRINT NAME (parent/guardian name if under 18 years of age) \_\_\_\_\_

X \_\_\_\_\_

Date: \_\_\_\_\_

Interviewer Initials \_\_\_\_\_