

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: \_\_\_\_\_

Mother's Maiden Name: \_\_\_\_\_ Gender: \_\_\_\_\_ Race: \_\_\_\_\_ Hispanic: \_\_\_\_\_ Telephone: \_\_\_\_\_

Child's 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 vaccine(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 \_\_\_\_\_

Signature of person to receive or person authorized to sign on behalf of the person who will receive requested vaccine(s). Immun1/ov111b him59/him59c1/nim001c Rev 12/07

Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Yrs. 00 Mos.

CPT Code	Vaccine	Route	Site Admin.	Dose Number	Manu	Lot Number	CDC Form Date	Diluent
90700	DTAP	IM		RV LV RD LD 1 2 3 4 5			05/17/2007	
90696	DTAP / IPV	IM		RV LV RD LD 1			05/17/2007	
90723	DTAP/IPV/HEPB	IM		RV LV RD LD 1 2 3			09/18/2008	
90698	DTAP/IPV/HIB	IM		RV LV RD LD 1 2 3 4			09/18/2008	
90632	HEPB-ADULT	IM		RV LV RD LD 1 2			03/21/2006	
90636	HEPB-HEPB	IM		RV LV RD LD 1 2 3			03/21/2006	
90633	HEPB-PED	IM		RV LV RD LD 1 2			03/21/2006	
90746	HEPB-ADULT	IM		RV LV RD LD 1 2 3			07/18/2007	
90744	HEPB-PED	IM		RV LV RD LD 1 2 3			07/18/2007	
90647	HIB	IM		RV LV RD LD 1 2 3			12/16/1998	
90649	HPV	IM		RV LV RD LD 1 2 3			03/30/2010	
90713	IPV	SC IM		RV LV RD LD 1 2 3 4			01/01/2000	

\* (RV) -Right Vastus Lateralis (LV) -Left Vastus Lateralis (RD) -Right Deltoid (LD) -Left Deltoid (SC) -Subcutaneous injection  
 (IM) -Intramuscular Injection Date Vaccinated \_\_\_\_\_ Initials \_\_\_\_\_

Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Yrs. 00 Mos.

CPT Code	Vaccine	Route	Site Admin.	Dose Number	Manu	Lot Number	CDC Form Date	Diluent
90734	MCV4	IM		1 2 3			01/28/2008	
90707	MMR	SC		1 2			03/13/2008	
90670	PCV13	IM		1 2 3 4			04/16/2010	
90732	PNEUMOVAX-ADULT	IM		1			10/06/2009	
90680	ROTAVIRUS	PO		1 2 3	ORAL		05/14/2010	
90736	SHINGLES	SC		1			10/06/2009	
90718	TD	IM		1 2 3 4 5			11/18/2008	
90715	TDAP	IM		1 2 3			11/18/2008	
90716	VAR	SC		1 2			03/13/2008	

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 (IM) -Intramuscular injection

Found in WIR? Yes  No

Immune Record Reviewed? Yes  No

PH Clinic \_\_\_\_\_

Date Vaccinated \_\_\_\_\_

Signature/Title of Person Administering Vaccine \_\_\_\_\_