DEPARTMENT OF HUMAN SERVICES
Division of Health

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:_____YRS_______MNS__

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 Would you like reminder/recall sent to you? __ Yes __ No Physician:________________

THE PERSON RECEIVING VACCINE TODAY:

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

Signature of person to receive or person authorized to sign on behalf of the person who will receive requested vaccine(s).