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 on this form is voluntary and the Social Security Number will be used by parent or guardian to access WIR.

Patient Name (last, first, middle initial)**:**		**Date of Birth:**
Name of Parent or Guardian Responsible for Patient:		**Relationship to Patient:**
Mother's Maiden Name (last, first, middle initial)**:**		**Social Security # of Patient:**
Street:		**City:**
State:	**Zip Code:**	**OK to share data with the Wisconsin Immunization Registry?** ☐ Yes ☐ No
Phone:	**Gender:** ☐ Male ☐ Female	**Is reminder or recall allowed?** ☐ Yes ☐ No
Race (Check One)**:** ☐ White ☐ African American ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaska Native ☐Asian ☐ Other		**Ethnicity** (check one)**:** ☐ Hispanic ☐ Non-Hispanic

Eligibility Status (Check all that apply)**:**
☐ Medicaid Eligible ☐ Badger Care ☐ Native American ☐ Medicare #_____
☐ Insured, Vaccines Not Covered ☐ Insured, Vaccines Covered ☐ No Health Insurance

Please answer the following question for the person to be vaccinated today:	**Yes**	**No**	**Unsure**
1. Are you sick today?	☐	☐	☐
2. Do you have any allergies to medications, food, vaccine component or latex?	☐	☐	☐
3. Have you ever had a serious reaction to a vaccine, including intranasal Flu-Mist, in the past?	☐	☐	☐
4. Have you, a sibling or a parent had a seizure, brain or other nervous system problems?	☐	☐	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
6. In the past 3 months, have you taken medications that weaken the immune system such as cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?	☐	☐	☐
7. In the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
8. Do you have any health problems with lung, heart, liver, kidney, metabolic disease (e.g., diabetes), neurologic or neuromuscular disease, asthma, anemia or another blood disorder?	☐	☐	☐
9. If between the ages of 2 through 4 years, has a healthcare provider said that the child had wheezing or asthma in the past 12 months?	☐	☐	☐
10. Are you pregnant or is there a chance you could become pregnant in the next 4 weeks?	☐	☐	☐
11. Have you received vaccinations in the past 4 weeks?	☐	☐	☐
12. Are you receiving aspirin therapy or aspirin-containing therapy?	☐	☐	☐
13. If less than 1 year of age, have you ever been told the child has had intussusception?	☐	☐	☐
14. Do you have an allergy to eggs or to a component of the influenza vaccine?	☐	☐	☐
15. Have you ever had Guillain-Barre syndrome?	☐	☐	☐
16. Do you live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation?	☐	☐	☐

I have been given all Vaccine Information Sheets (VIS) and have had explained to me information about the disease(s) and vaccines(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 about 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/Badger Care recipient I cannot be charged an administration fee or asked for any type of donation for the administration of any state-supplied vaccine. I agree that if I am a Medicare recipient, Medicare may be billed for this service. ★

SIGNATURE - Person to receive vaccine or person authorized to sign on the patient's behalf.	**Date Signed:**