# Wisconsin Immunization Registry
## 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.

| **CLIENT ID** | **CHART NUMBER** |
|---|---|

Patient's Name (Last, First, Middle) | Date of Birth (mm/dd/yyyy)

Social Security Number | Gender ☐ Male ☐ Female | Ethnicity (Check One) ☐ Hispanic ☐ Non-Hispanic

Race (Check One)

☐ American Indian or Alaska Native ☐ Other ☐ Native Hawaiian or Other Pacific Islander
☐ Asian ☐ White ☐ Black or African American

Mother's (if married, patient's) Maiden Name (Last, First, Middle)

Name of Physician (First Last) | County Primary Address | Country of Birth

Name of Parent or Guardian Responsible for Patient (Last, First, Middle) | Relationship to Patient

Address | P.O. Box | Email address (if applicable)

City | State | Zip Code | Telephone Number ( ) | Extension

Is reminder/recall contact allowed? ☐ Yes ☐ No

Would you like reminder/recall sent to you? ☐ Yes ☐ No

**Eligibility Status**
**(Check all that apply)**
**This section must be completed.**

☐ Medicare ☐ Medicaid Eligible ☐ Insured, Vaccines Covered
☐ Badger Care ☐ Native American or Alaskan Native ☐ No Health Insurance
☐ Insured, Vaccines Not Covered

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 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**

16 May 2024

**Wisconsin Immunization Registry**
**Vaccine Administration Record**

Patient's Name (Last, First, Middle)

Date of Birth (mm/dd/yyyy)

**FOR OFFICE USE**

| Vaccine | VIS Date | Body Route | Body Site* | |
|---|---|---|---|---|
| DTP/aP | 08/06/2021 | IM | RV LV RD LD | |
| HPV | 08/06/2021 | | RV LV RD LD | |
| HepA | 10/15/2021 | IM | RV LV RD LD | |
| HepB | 05/12/2023 | IM | RV LV RD LD | |
| Hib | 08/06/2021 | IM | RV LV RD LD | |
| Influenza | 08/06/2021 | IM | RV LV RD LD | |
| MMR | 08/06/2021 | SC | RV LV RD LD | |
| Meningo | 08/06/2021 | IM | RV LV RD LD | |
| Pertussis/Tdap | 08/06/2021 | IM | RV LV RD LD | |
| Pneumococcal | 05/12/2023 | | RV LV RD LD | |
| Polio | 08/06/2021 | | RV LV RD LD | |
| Rotavirus | 10/15/2021 | PO | RV LV RD LD | |
| Varicella | 08/06/2021 | SC | RV LV RD LD | |
| **Other** | | | | |

*RV = Right Vastus Lateralis LV = Left Vastus Lateralis RD = Right Deltoid LD = Left Deltoid Subcutaneous injections are administered in the muscle "area".

SIGNATURE AND TITLE - Person Administering Vaccine

**X**

Date Vaccine Administ