

Wisconsin Immunization Registry
Organization: Crawford County Health Department Site: 1Prairie du Chien

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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Ethnicity (Check One) <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
Race (Check One) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Other <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Would you like reminder/recall sent to you? <input type="checkbox"/> Yes <input type="checkbox"/> No
Eligibility Status (Check all that apply) This section must be completed. <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid Eligible <input type="checkbox"/> Insured, Vaccines Covered <input type="checkbox"/> Badger Care <input type="checkbox"/> Native American or Alaskan Native <input type="checkbox"/> No Health Insurance <input type="checkbox"/> 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 X	Date Signed
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Patient's Name (Last, First, Middle)

Date of Birth (mm/dd/yyyy)

FOR OFFICE USE

Vaccine	VIS Pub. Date	VIS Pres. Date	Recommended Date	Body Route	Body Site*
DTP/aP	04/01/2020			IM	RV LV RD LD
	Pediarix~2HC47~GlaxoSmithKline (S		Infanrix~G5BE3~GlaxoSmithKline (SmithKli	KINRIX~HB7L7~GlaxoSmithKline (SmithKli	
HPV	10/30/2019				RV LV RD LD
	Gardasil 9~R032766~Merck & Co., I				
HepA	07/28/2020			IM	RV LV RD LD
	Havrix-Peds 2 Dose~52ZY4~GlaxoS		Havrix-Adult~Y29KL~GlaxoSmithKline (Smit		
HepB	08/15/2019			IM	RV LV RD LD
	Pediarix~2HC47~GlaxoSmithKline (S		Engerix-B Peds~J7H4D~GlaxoSmithKline (S		
Hib	10/30/2019			IM	RV LV RD LD
	PedvaxHIB~R014261~Merck & Co., I				
Influenza	08/15/2019			IM	RV LV RD LD
	FluLaval Quad, P-Free~2SM24~Glax		FluLaval Quad, P-Free~CF4GR~	Fluzone Quad~UJ452AC~Sanofi Pasteur In	
MMR	08/15/2019			SC	RV LV RD LD
	MMR II~S029455~Merck & Co., Inc.		Proquad~T013542~Merck & Co., Inc.		
Meningo	08/15/2019			IM	RV LV RD LD
	Menveo~AMVA377A~Novartis Phar				
Pertussis/Tdap	04/01/2020			IM	RV LV RD LD
	Boostrix~C5JL7~GlaxoSmithKline (S				
Pneumococcal	10/30/2019				RV LV RD LD
	Prevnar 13~AL8456~Wyeth				
Polio	10/30/2019				RV LV RD LD
	IPOL~P1F491M~Sanofi Pasteur Inc.		Pediarix~2HC47~GlaxoSmithKline (SmithKli	KINRIX~HB7L7~GlaxoSmithKline (SmithKli	
Rotavirus	10/30/2019			PO	RV LV RD LD
	ROTARIX~F9MF2~GlaxoSmithKline				
Varicella	08/15/2019			SC	RV LV RD LD
	Varivax~S002735~Merck & Co., Inc.		Varivax~S019583~Merck & Co., Inc.	Proquad~T013542~Merck & Co., Inc.	
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

Date Vaccine Adm

X