WEST ALLIS HEALTH DEPARTMENT
7120 WEST NATIONAL AVENUE, WEST ALLIS, WI 53214 – 414-302-8600

VACCINE ADMINISTRATION RECORD

Last Name: **Legal First Name:**

Middle Name: **Area Code:** — **Phone:** —

Address: **Apt. #**

City: **State:** W I **Zip Code:**

Birth Date: / / **Age:** in (check one) ☐ years ☐ months **Gender:** (check one) ☐ Male ☐ Female

Mother's Maiden Name

For people younger than 18 years of age: Name of Parent or Legal Guardian

Last Name **First Name**

Middle Name:

Relationship to Patient____________________________

RACE (CHECK ONE) ❑ American Indian or Alaska Native ❑ Asian ❑ Native Hawaiian or other Pacific Islander ❑ Black or African American ❑ White ❑ Other Race

ETHNICITY: ❑ Hispanic ❑ Non-Hispanic

CHECK ALL THAT APPLY: ❑ Medicare ❑ Badger Care ❑ Insured, Vaccines Not Covered ❑ Mass Clinic Supply ❑ Native American/Alaskan ❑ No Health Insurance ❑ Insured, Vaccines Covered ❑ Medicaid Eligible ❑ Specific Vaccine Eligible

Medicare / Medicaid Number

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 have been offered a copy of the City of West Allis Privacy statement and have had a chance to ask questions. I authorize the release of this information to Medicaid, to process this claim.

I have been given a copy and have read, or have had explained to me, information about the disease(s), vaccine(s) checked below and Vaccine Information Sheet(s) (VIS). I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine(s) checked below be given to me or to the person named above, for whom I am authorized to make this request.

NOTE: Immunization history will be placed in the Wisconsin Immunization Registry (WIR) to help your health care provider in record-keeping and tracking future vaccines that may be needed. Immunization information may be shared with other providers, public health departments, schools and health insurers in accordance with the laws of the State of Wisconsin. You must notify the West Allis Health Department in writing if you do not wish this information to be shared.

X / /

SIGNATURE of person to receive vaccine or person authorized to sign on behalf of the person who will receive vaccines(s). **DATE**

V A C C I N E (S) **Staff to Complete**

❑ DTaP	❑ DTaP-IPV-Hib (Pentacel)	❑ Hep B (A, P)	❑ IPV	❑ PCV13	❑ Td	❑ Other
❑ DTaP-IPV (Kinrix/Quadracel)	❑ Flu (A, P)	❑ Hib	❑ Meningococcal conjugate	❑ PPSV23	❑ Tdap	__________
❑ DTaP-IPV-Hep B (Pediarix)	❑ Hep A (A, P)	❑ HPV	❑ MMR	❑ Rotavirus	❑ Varicella	

For Official Use Only

Does child (6 mo. – 8 yr.) need 2nd flu dose this season? ❑ Yes ❑ No

	AGE GROUP	DOSAGE	TODAY'S DOSE IS:	ROUTE
❑	6 months – 35 months	0.25 ml.	1 or 2	IM
❑	6 months – 35 months	0.50 ml.	1 or 2	IM
❑	3 – 8 years	0.50 ml.	1 or 2	IM
❑	9 – 18 years	0.50 ml.	1	IM

	AGE GROUP	DOSAGE	PRODUCT	ROUTE
❑	19 – 64 years	0.50 ml.	Quadrivalent	IM
❑	65 – up	0.50 ml.	Quadrivalent (not High Dose)	IM
❑	65 – up	0.50 ml.	High Dose (Trivalent)	IM

❑ WA Employee ❑ WA Employee spouse or child ❑ Waived ❑ Paid
❑ WM Employee ❑ Retiree/Spouse ❑ WEA / ❑ Non-WEA (School District Employee)

Screener's Signature______________________________ Date: __ __ / __ __ / __ __ __ __

Administration

Manufacturer: ☐ Sanofi Pasteur ☐ GSK	Dose: ☐ .25 ml ☐ .5 ml	Site: ☐ RD ☐ LD ☐ RV ☐ LV
Lot #/ Exp. Date (place sticker here) VIS Statement (08/07/2015)	Administered by: ____________ Date: __ __ / __ __ / __ __ __ __	

5/25/18