# Wisconsin Immunization Registry Vaccine Administration Record

We will put this information in a computer database called the Wisconsin Immunization Registry (WIR). Your doctor, school, and health department can see it. You don't have to answer every question. Please ask if you have questions.

**Last name:** _____ **First name:**_____ **Middle initial:**____

**Preferred name:** _____ **Date of birth:** _____ **Age:** _____

**Address:**_____ **County:**_____

**City:**_____ **State:**_____ **Zip code:**_____

**Telephone:**_____ **Email:**_____

**Gender:** ☐ Male ☐ Female ☐ Other

**Ethnicity:** ☐ Hispanic ☐ Not Hispanic

**Race:** ☐ American Indian or Alaskan Native
☐ Asian ☐ Black or African American
☐ Native Hawaiian or other Pacific Islander
☐ White ☐ Other

**Mother's first name and maiden name (last name before marriage):** _____

**Health Insurance Status:**
☐ Insured, vaccines covered ☐ Insured, vaccines NOT covered
☐ BadgerCare (Medicaid) ☐ Medicare ☐ Native American/Alaskan Native
☐ Medical assistance (example: You have a Forward Card) ☐ No insurance

**Please answer the next two questions if you are completing this form for someone else:**

Are you this person's parent or guardian? ☐ Yes ☐ No

Parent or guardian's first and last name:_____

## Consent

- 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.
- I acknowledge that I have received a copy of the "Privacy Practices Notices" of Public Health Madison & Dane County.
- I understand that if I am a BadgerCare (Medicaid) 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.

**Your signature:**_____ **Date:**_____

**If guardian gives verbal consent over the phone, provide their first and last name:** _____

## For Office Use Only

| Vaccine | VIS given | Route | Site | Trade name/Manufacturer Lot Number | Expiration Date |
|---|---|---|---|---|---|
| COVID-19 | | | | | |
| DTP/aP | | | | | |
| HepA | | | | | |
| HepB | | | | | |
| Hib | | | | | |
| HPV | | | | | |
| Influenza | | | | | |
| Meningo | | | | | |
| MMR | | | | | |
| Pertussis/Tdap | | | | | |
| Pneumo-Poly | | | | | |
| Pneumococcal | | | | | |
| Polio | | | | | |
| Rabies | | | | | |
| RSV | | | | | |
| Rotavirus | | | | | |
| Smallpox | | | | | |
| Varicella | | | | | |

Signature and Title of Person Administering Vaccine:_____ Date:_____