☐ *Urgent* ☐ *Copied for MA Billing*
☐ *Posted* ☐ *R.C. Employee Billing List*
☐ *No Part B* ☐ *Copied for Employer Billing*

ROCK COUNTY PUBLIC HEALTH DEPARTMENT
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.

Patient's Name (Last, First, Middle Initial) Include maiden name if married	**Mother's Maiden Name (Last Name, First Name)**

Address	**City**	**County**	**State**	**Zip Code**

Telephone Number	**Date of Birth (mm/dd/yyyy)**	**Age**	**Gender** ☐ **Male** ☐ **Female**

Race (check one)
☐ **African American** ☐ **American Indian or Alaskan Native** ☐ **Asian**
☐ **Native Hawaiian/Pacific Islander** ☐ **White** ☐ **Other**

Ethnicity (check one)
☐ **Hispanic or Latino** ☐ **Non-Hispanic or Latino**

Social Security Number (Optional – This is needed for you to access you or your child's record on the Wisconsin Immunization Registry)

Name of Physician	**Name of Clinic**

Eligibility Status. This section must be completed.
☐ **Insured, Vaccines Covered** ☐ **Badger Care ID# _____** ☐ **Native American** ☐ **Medicare (complete Medicare section below)**
☐ **Insured, Vaccines Not Covered** ☐ **No Health Insurance** ☐ **Medicaid Eligible** ☐ **Rock County Employee/Family Member**

BADGER CARE/MEDICARE RECIPIENTS:
By signing below, I authorize the release of medical or other information necessary to process this claim. I also request payment of government or medical benefits to the Rock County Public Health Department.

Medicare Claim #	**Medicare Supplement Name**	**Supplement ID #**	**Supplement Group #**	**Supplement Phone #**

Minors Only: Name of Parent or Guardian Responsible for Patient (Last, First, Middle Initial)	**Relationship to Patient**

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 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 mine or 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 ONLY if you do NOT give your permission. ☐

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

Patient's Name (Last, First)

FOR OFFICE USE

Vaccine	State or Purchased	Refused Vaccine	Route	Site Admin. *	Dose Number	Manufacturer	Lot Number	VIS Form Date ✡
☐ DTap	☐ S ☐ P	☐	IM	RV LV RD LD	1 2 3 4 5			4/1/20 (DTaP), 4/1/20 (Multi)
☐ DTap – Hep B – IPV (Pediarix)	☐ S ☐ P	☐	IM	RV LV RD LD	1 2 3	GSK		4/1/20 (DTaP), 8/15/19 (Hep B), 10/30/19 (Polio), 4/1/20 (Multi)
☐ DTap – IPV (Kinrix)	☐ S ☐ P	☐	IM	RV LV RD LD	1	GSK		4/1/20 (DTaP), 10/30/19 (Polio)
☐ DTap – IPV – Hib (Pentacel)	☐ S ☐ P	☐	IM	RV LV RD LD	1 2 3 4	Sanofi		4/1/20 (DTaP), 10/30/19 (Hib), 10/30/19 (Polio), 4/1/20 (Multi)
☐ Hep A	☐ S ☐ P	☐	IM	RV LV RD LD	1 2			7/28/20 (Hep A)
☐ Hep B	☐ S ☐ P	☐	IM	RV LV RD LD	1 2 3 4			8/15/19 (Hep B), 4/1/20 (Multi)
☐ Hep A – Hep B (Twinrix)	☐ S ☐ P	☐	IM	RV LV RD LD	1 2 3	GSK		7/28/20 (Hep A), 8/15/19 (Hep B)
☐ Hib	☐ S ☐ P	☐	IM	RV LV RD LD	1 2 3 4			10/30/19 (Hib), 4/1/20 (Multi)
☐ HPV (Human papillomavirus)	☐ S ☐ P	☐	IM	RV LV RD LD	1 2 3	Merck		10/30/19 (HPV-Gardasil 9)
☐ Influenza	☐ S ☐ P	☐	IM	RV LV RD LD	1 2			8/15/19
☐ Meningococcal Conjugate (MCV4)	☐ S ☐ P	☐	IM	RV LV RD LD	1 2	Sanofi		8/15/19 (Meningo)
☐ MMR	☐ S ☐ P	☐	SQ	RV LV RD LD	1 2	Merck		8/15/19 (MMR)
☐ MMR – Varicella (Proquad)	☐ S ☐ P	☐	SQ	RV LV RD LD	1 2	Merck		8/15/19 (MMRV)
☐ Pneumococcal Conjugate (PCV13)	☐ S ☐ P	☐	IM	RV LV RD LD	1 2 3 4	Wyeth		10/30/19 (Pneumo), 4/1/20 (Multi)
☐ Pneumovax 23	☐ S ☐ P	☐	IM	RV LV RD LD	1			10/30/19 (Pneumovax)
☐ Polio	☐ S ☐ P	☐	SQ	RV LV RD LD	1 2 3 4	Sanofi		10/30/19 (Polio), 4/1/20 (Multi)
☐ Rotavirus	☐ S ☐ P	☐	Oral		1 2 3			10/30/19 (Rota)
☐ Shingles (Shingrix)	☐ S ☐ P	☐	IM	RV LV RD LD	1 2			10/30/19 (Shingles)
☐ Td	☐ S ☐ P	☐	IM	RV LV RD LD	1 2 3			4/1/20 (Td)
☐ Tdap	☐ S ☐ P	☐	IM	RV LV RD LD	1			4/1/20 (Tdap)
☐ Varicella	☐ S ☐ P	☐	SQ	RV LV RD LD	1 2	Merck		8/15/19 (Varicella)
☐ Other	☐ S ☐ P	☐						

*RV = R Vastus Lateralis, LV – L Vastus Lateralis, RD = R Deltoid, LD = L Deltoid Subcutaneous injections are administered in the muscle "area".

✡ Use most current Vaccine Information Statement (VIS) or if appropriate use the Multi Vaccines Information Statement (VIS).

SIGNATURE AND TITLE – Person Administering Vaccine

Date Vaccine Administered and VIS offered

CLINIC SITE: ☐ North Office ☐ South Office ☐ Other _____

Rock County Health Department
3328 US Hwy 51 North, Janesville 61 Eclipse Center, Beloit

Screening Questionnaire for General Immunizations

The following questions will help us determine which vaccines may be given today.
If a question is not clear, please ask the nurse to explain it.

Please sign below after completion	**Yes**	**No**	**Don't Know**
Does the person to be vaccinated today:			
• Have any symptoms of illness at the present time?			
• Have allergies to medications, food (including eggs), or any vaccine?			
• Have a history of a serious reaction to any vaccine in the past?			
• Have asthma, lung, liver, kidney or heart disease, diabetes, anemia or other blood or metabolic disorder(s)?			
• Have cancer, leukemia, AIDS, or any other immune system problem?			
• Have a personal or immediate family history of seizures, brain or other nervous system problems?			
• Take cortisone, prednisone, or other steroids or anticancer drugs, or had radiation treatments in the past 3 months?			
• Have a history of receiving a transfusion of blood or blood products, immune (gamma) globulin or an antiviral drug in the past year?			
• Have a chance of being pregnant or becoming pregnant during the next month?			
• Live or expect to have close contact with a person whose immune system is severely compromised and must be in protective isolation?			
Has the person receiving the vaccine(s) today:			
• Ever had an outbreak of shingles in the past?			
• Received other vaccinations in the past 4 weeks?			
• Ever had Guillian-Barre syndrome?			

Form completed by: _____ Date: _____

Form reviewed by: _____ Date: _____
(RCHD Staff)

Did you bring your child's immunization record card with you? ☐ Yes ☐ No

It is important to have a personal record of your child's vaccinations. If you don't have a record card, ask the child's health care provider to give you one! Bring this record with you every time you seek medical care for your child. Make sure your health care provider records all your child's vaccinations on it.