Rock County Public Health Department
Travel Vaccine Administration Record

I have had an opportunity to review vaccination information sheets for each of the vaccines/medications checked below. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits of the vaccine(s) /medication(s) requested and ask that the vaccine(s)/medication(s) checked below be given to me or to the person named below for whom I am authorized to make this request.

Vaccine(s)/Medication(s) to be given today:

☐ Hepatitis A ☐ Hepatitis B ☐ Influenza ☐ Polio ☐ Japanese Encephalitis

☐ Meningococcal ☐ MMR/MMRV ☐ Rabies ☐ Tdap ☐ Tetanus

☐ Twinrix ☐ Typhoid (Injectable) ☐ Typhoid (Oral) ☐ Yellow Fever ☐ Other _____

☐ Malaria Prescription given:

☐ Mefloquine _____ ☐ Chloroquine _____ ☐ Doxycycline _____ ☐ Malarone _____ ☐ Other _____

INFORMATION ABOUT THE PERSON TO RECEIVE VACCINE (PLEASE PRINT)

Name: (Last , First, Middle Initial) Include Maiden Name if Married	Mother's Maiden Name (Last Name, First Name)
Address: Street / City / State / Zip Code	

Telephone	County	Clinic/Physician	Birthdate	Age	Sex ☐M ☐F

I give permission to enter my immunization records in the Wisconsin Immunization Registry for the purpose of maintaining a complete record.
Check here ONLY if you do NOT give your permission. ☐

Social Security #_____-_____-_____
(This is needed for you to access your record on the WIR)

Eligibility Status: **This section must be completed**

☐ Insured, Travel Vaccines Covered ☐ BadgerCare ID#_____ ☐ Native American ☐ Medicare
☐ Insured, Travel Vaccines Not Covered ☐ No Health Insurance ☐ Medicaid Eligible

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

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Signature of person to receive vaccine or person authorized to make the request (parent or guardian)

Date:

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 ✡
☐ Hepatitis A	☐ S ☐ P	☐	IM	RV LV RD LD	1 2			7/28/20
☐ Hepatitis B	☐ S ☐ P	☐	IM	RV LV RD LD	1 2 3 4			8/15/19
☐ Hepatitis A – Hepatitis B (Twinrix)	☐ S ☐ P	☐	IM	RV LV RD LD	1 2 3	GSK		7/28/20 (Hep A), 8/15/19 (Hep B)
☐ Influenza	☐ S ☐ P	☐	IM	RV LV RD LD	1 2			8/15/19
☐ ISG	☐ S ☐ P	☐	IM	RV LV RD LD	1			
☐ Japanese Encephalitis	☐ S ☐ P	☐	IM	RV LV RD LD	1 2 3			8/15/19
☐ Meningococcal	☐ S ☐ P	☐	IM	RV LV RD LD	1 2	Sanofi		8/15/19
☐ MMR	☐ S ☐ P	☐	SQ	RV LV RD LD	1 2	Merck		8/15/19
☐ MMR – Varicella (Proquad)	☐ S ☐ P	☐	SQ	RV LV RD LD	1 2	Merck		8/15/19
☐ Rabies	☐ S ☐ P	☐	IM	RV LV RD LD	1 2 3			1/8/20
☐ Polio	☐ S ☐ P	☐	SQ	RV LV RD LD	1 2 3 4	Sanofi		10/30/19
☐ Td	☐ S ☐ P	☐	IM	RV LV RD LD	1 2 3			4/1/20
☐ Tdap	☐ S ☐ P	☐	IM	RV LV RD LD	1			4/1/20
☐ Typhoid (Injectable)	☐ S ☐ P	☐	IM	RV LV RD LD	1			10/30/19
☐ Typhoid (Oral)	☐ S ☐ P	☐	PO		1			10/30/19
☐ Yellow Fever	☐ S ☐ P	☐	SQ	RV LV RD LD	1			4/1/20
☐ 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

Rock County Public Health Department
Screening Questionnaire for Travel Immunizations

The following questions will help us determine which vaccine 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
• Is the child / adult receiving the vaccine sick today?			
• Does the child / adult receiving the vaccine have allergies to medications, food, or any vaccine?			
• Has the child / adult receiving the vaccine had a serious reaction to a vaccine in the past?			
• Has the child / adult receiving the vaccine had a seizure or brain problem?			
• Does the child / adult receiving the vaccine have cancer, leukemia, AIDS, or any other immune system problem?			
• Has the child / adult receiving the vaccine taken cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments in the past 3 months?			
• Has the child / adult receiving the vaccine received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin in the past year?			
• Is the person receiving the vaccine breastfeeding, pregnant or could they become pregnant during the next month?			
• Has the child / adult receiving the vaccine received vaccinations in the past 4 weeks?			
• Does the child / adult have a history of heart, kidney, lung, liver disease, thymic disease, myasthenia gravis, multiple sclerosis or mental illness? If so, please list:			
• Is the child / adult taking any medication. If yes, please list:			

Form completed by: _____ Date: _____

Form reviewed by: _____ Date: _____