Wisconsin Immunization Registry
Vaccine Administration Record

This information will be put into a computer database called WIR. Your doctor, school and health department can see it. You don't have to provide all of this information. Please ask if you have questions.

Last Name:_____ First:_____ Middle:_____

If child, are you the child's parent? ☐ Yes ☐ No Parent First/Last Name:_____

Date of Birth: month_____ day_____ year_____ age_____

Social Security Number:_____ (used to look up your own record)

Gender: ☐ Male ☐ Female

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

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

Maiden name (last name before marriage) and first name of mother:_____, _____

If child, responsible person's Last Name:_____ First Name:_____

Address:_____ County:_____

City:_____ State:_____ Zip Code:_____

Telephone:_____

Email Address:_____

Would you like reminders sent to you? ☐ Yes ☐ No

Health insurance? ☐ Yes ☐ No

What kind of insurance?
☐ Badger Care
☐ Medical Assistance
☐ Medicare
☐ Insurance, but vaccines aren't covered
☐ Insurance and vaccines are covered
☐ Native American/Alaskan Native
☐ Other _____

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 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 ☐

X Signature:_____ **Date:** _____

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					
Rotavirus					
Smallpox					
Varicella					
Signature and Title – Person Administering Vaccine:_____ Date:_____					