DEPARTMENT OF HEALTH & FAMILY SERVICES **STATE OF WISCONSIN**
Division of Public Health Wis. Stats. 252.04
DPH 4702 (Rev. 07/06)

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 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.

Patient's Name (Last, First, Middle Initial)		**Date of Birth** (mm/dd/yyyy)	
Address		**Age**	Weight (Only include if <100 lbs or a child)
City	**County**	**State**	**Zip Code**
Telephone Number	**Gender** ☐ Male ☐ Female		
Race (Check one) ☐ African American ☒ Asian ☐ Caucasian ☐ Native American ☐ Other		**Ethnicity** (Check one) ☐ Hispanic ☐ Non-Hispanic	

If you are a family member of a City of Oak Creek employee, please provide employee name:

Name of Physician

Name of Parent/Guardian Responsible for Minor Patient (Last, First, Middle Initial)	Relationship to Patient

Okay to share immunization data with Wisconsin Immunization Registry? ☐ Yes ☐ No

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 my privacy rights and have been offered a written Notice of Privacy Practices of the Oak Creek Health Department.

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

FOR OFFICE USE

Vaccine	Route	Site Admin.*	Dose Number	Manufacturer	Lot Number	CDC Form Date
Pneumonia	SQ or IM	RD LD	1 B			10/30/2019 PPSV 10/30/2019 PCV13
Inactivated Influenza	IM	RV LV RD LD	1 2 B			08/06/2021
Other -	SQ or IM	RV LV RD LD	1 2 3 4 5			

RV=R Vastus Lateralis LV=L Vastus Lateralis RD=R Deltoid LD=L Deltoid

SIGNATURE AND TITLE – Person Administering Vaccine	Date Vaccine Administered/VIS given

Oak Creek Health Department, 8040 S. 6th Street, Oak Creek, WI 53154 (414)766-7950

Please complete screening questions on page 2

Patient Name: _____ **Date of Birth:** _____

Screening Questionnaire for Inactivated Influenza Vaccination

For patients to be vaccinated: The following questions will help us determine which vaccine you may be given today. If a question is not clear, please ask the nurse to explain it.

	No	Yes	Not Sure
1. Is the person to be vaccinated sick today?	☐	☐	☐
2. Does the person to be vaccinated have an allergy to formaldehyde, eggs, or octylphenol ethoxylate (Triton® X-100)?	☐	☐	☐
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	☐	☐	☐
4. Has the person to be vaccinated ever had Guillain-Barre syndrome?	☐	☐	☐

Form completed by: _____ Date: _____

☐ Client ☐ Guardian

Client has been screened and counseled for side effects for vaccines given

by: _____ Date: _____