Vaccine Administration Record and Consent Form

The information gathered on this form is confidential. **Please complete all questions.**

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

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

Address:_____

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: (check all that apply)

☐ Insured, vaccines covered ☐ Insured, vaccines NOT covered

☐ BadgerCare (Medicaid) ☐ Medicare ☐ Native American/Alaskan Native

☐ Medical assistance (example: You have a Forward Card) ☐ No insurance

Consent for Vaccination. Information collected on this form will be used to document authorization for receipt of vaccines. The information will 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. As required by privacy regulations, I hereby acknowledge that I have received or been offered a current copy of this provider's "Notice of Privacy Practices." Check box if you do not want your information shared with WIR ☐.

I have been given a copy and have read/or have had explained to me the Vaccine Information Sheet, Vaccine Fact Sheet or FDA Emergency Use Authorization Fact Sheet for the vaccines to be given. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of this vaccine(s) and ask that the vaccine(s) be given to me or the person for whom I am authorized to make this request.

Consent to Bill Insurance. You have my permission to bill my health insurance provider for all fees associated with the administration of vaccinations, if applicable. I authorize the release of information to my health insurance provider needed to complete and verify payment. The Oak Creek Health Department participates and accepts assignment of Medicare part B and some other health insurance plans. However, if a health insurance plan denies a claim for reimbursement for vaccination, payment is the responsibility of the client. I understand that regardless of any insurance coverage I may have, I am responsible for payment of my account.

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 administrative fee or asked for any type of donation for the administration of any vaccine that is being provided.

Print parent/guardian name, if different from client:_____ **Date:**_____

Client/parent/guardian signature:_____ **Date:**_____

For Office Use Only

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

Signature and Title of Person(s) Administering Vaccine(s): _____ Date:_____

Site abbreviations: LVL- Left Vastus Lateralis, RVL- Right Vastus Lateralis, LD- Left Deltoid, RD- Right Deltoid, LA- Left arm, RA- Right arm
Route abbreviations: SQ- subcutaneuous, IM- Intramuscular, O- Oral, N- Nasal

OAKCREEK WISCONSIN HEALTH

Updated: August 2024