#  Wisconsin Immunization Registry

# Vaccine Administration Record

The information on this form will be kept to show that you agree to be immunized/have your child immunized. 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

Date of Birth: month       day       year

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:       P.O. Box:

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

I have read, or someone explained to me, information about diseases and the vaccines me/my child will get. I have been able to ask questions and get answers. I understand the benefits and risks of the vaccines. Please immunize me/my child.

Sign your name: Date: