

Clinic Name/Address:

Patient Name: _____ Record #: _____

Date of Birth: _____ Patient Age: _____

* Site: RA – Right Arm LA – Left Arm PO- Orally ID- Intradermal IN- Intranasal IM- Intramuscular SQ- Subcutaneous
RT - Right Thigh LT – Left Thigh

Vaccine (Circle) **Place √ in box "C" if combination vaccine given (e.g. Comvax®)	VACCINE ADMINISTERED						VFC Status ***	VACCINE			VACCINE INFORMATION STATEMENTS (VIS)		Vaccine Administrator Signature
	Date mm/dd/yy	Patient Age	Dosage	Route	Site*	C**		Manufacturer	Lot Number	Expiration Date	Date VIS Published	Date VIS Provided	
DTaP or DT – 1				IM									
DTaP or DT – 2				IM									
DTaP or DT – 3				IM									
DTaP or DT – 4				IM									
DTaP or DT – 5				IM									
Tdap-1				IM									
Rotavirus-1				PO									
Rotavirus-2				PO									
Rotavirus-3				PO									
Td – 1				IM									
Td – 2				IM									
Hib – 1				IM									
Hib – 2				IM									
Hib – 3				IM									
Hib – 4				IM									
Hep B – 1				IM									
Hep B – 2				IM									
Hep B – 3				IM									
Polio – 1				SQ/IM									
Polio – 2				SQ/IM									
Polio – 3				SQ/IM									
Polio – 4				SQ/IM									
MMR – 1				SQ									
MMR – 2				SQ									
Varicella – 1				SQ									
Varicella – 2				SQ									
MCV4				IM									
MPSV4				SQ									
Hep A - 1				IM									
Hep A - 2				IM									
PCV13 – 1				IM									
PCV13 – 2				IM									
PCV13 – 3				IM									
PCV13 – 4				IM									
Influenza –1 TIV/LAIV				IM/IN/ID									
Influenza –2 TIV/LAIV				IM/IN/ID									
Zoster - 1				SQ									
PPSV23 – 1				SQ/IM									
PPSV23 – 2				SQ/IM									
HPV – 1				IM									
HPV – 2				IM									
HPV - 3				IM									

ADVERSE REACTION (AR)

Date	Immunization	Reaction

You must file a Vaccine Adverse Event by calling 1-877-721-0366 or logging on to www.vaers.org



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***** VFC Status:** Complete the VFC Status for every vaccination given to a child less than 19 years of age and is eligible to receive VFC vaccines using codes: **M**=Child has Medicaid, **PC**= PeachCare, **N**= Not Insured, **U**= Underinsured, **AI/AN**=American Indian or Alaska Native, or indicate if **PI** =Private insurance patient (**not eligible for VFC**).