PEDIATRIC IMMUNIZATION RECORD

Patient Name:_____

Date of birth:___/___/_____ Record #_____

Allergies or Reactions:_____

History of Chickenpox? YES or NO If yes, date if known:_____

Vaccine (circle correct vaccine)	Date Admin			Age at the time	VIS Form Given			Manuf Abbr*	Lot Number	Dose	Admin Site	Route	VFC	Provider Initials*** or Outside Provider Name
	Mo	Day	Yr		Type	Mo	Yr							
DT DTaP					DTP					0.5cc	LT RT LA RA	IM		
DT DTaP					DTP					0.5cc	LT RT LA RA	IM		
DT DTaP					DTP					0.5cc	LT RT LA RA	IM		
DT DTaP DTaP-Hib					DTP Hib					0.5cc	LT RT LA RA	IM		
DT DTaP					DTP					0.5cc	LT RT LA RA	IM		
Td					Td					0.5cc	LT RT LA RA	IM		
DTaP - HepB - IPV					DTP Hep B Polio					0.5cc	LT RT LA RA	IM		
DTaP - HepB - IPV					DTP Hep B Polio					0.5cc	LT RT LA RA	IM		
DTaP - HepB - IPV					DTP Hep B Polio					0.5cc	LT RT LA RA	IM		
Hep B					Hep B						LT RT LA RA	IM		
Hep B					Hep B						LT RT LA RA	IM		
Hep B					Hep B						LT RT LA RA	IM		
Hep B-Hib					Hep B Hib					0.5cc	LT RT LA RA	IM		
Hep B-Hib					Hep B Hib					0.5cc	LT RT LA RA	IM		
Hep B-Hib					Hep B Hib					0.5cc	LT RT LA RA	IM		
Hib					Hib					0.5cc	LT RT LA RA	IM		
Hib					Hib					0.5cc	LT RT LA RA	IM		
Hib					Hib					0.5cc	LT RT LA RA	IM		
Hib					Hib					0.5cc	LT RT LA RA	IM		
IPV					Polio					0.5cc	LT RT LA RA	SQ		
IPV					Polio					0.5cc	LT RT LA RA	SQ		
IPV					Polio					0.5cc	LT RT LA RA	SQ		
IPV					Polio					0.5cc	LT RT LA RA	SQ		
MMR MR Rubeola					MMR					0.5cc	LT RT LA RA	SQ		
MMR MR Rubeola					MMR					0.5cc	LT RT LA RA	SQ		
Varicella					Var					Vial	LT RT LA RA	SQ		
Varicella (age 13 and over)					Var					Vial	LT RT LA RA	SQ		
PCV7					PCV					0.5cc	LT RT LA RA	IM		
PCV7					PCV					0.5cc	LT RT LA RA	IM		
PCV7					PCV					0.5cc	LT RT LA RA	IM		
PCV7					PCV					0.5cc	LT RT LA RA	IM		

*** Manufacturers: M = Merck; A = Aventis Pasteur; W = Wyeth; G = GlaxoSmithKline**

**** VIS Language given, if not English: _____**

*** PROVIDER INFORMATION

First Name	MI	Last Name	Title	Full Signature	Initials

Tuberculin Test

Date Admin			Test Type		Provider*** placing the test	Provider*** reading the test	Results	Notes
Mo	Day	Yr	PPD	Tine				

Vaccines for Children (VFC) Program Eligibility

Check (in pencil) the current VFC eligibility status below:

☐ Patient is **privately insured** and **IS NOT** eligible for the VFC Program.

Screening date:_____ Screening date:_____ Screening date:_____

☐ Patient is **Medicaid** enrolled and **IS** eligible for VFC Program vaccines.

Screening date:_____ Screening date:_____ Screening date:_____

☐ Patient is **Uninsured** and **IS** eligible for VFC Program vaccines.

Screening date:_____ Screening date:_____ Screening date:_____

☐ Patient is **Underinsured** and **IS** eligible for VFC Program vaccines **at FQHC or RHC only**.

Screening date:_____ Screening date:_____ Screening date:_____

☐ Patient is **Native American** and **IS** eligible for VFC Program vaccines.

Vaccine (circle correct vaccine)	Date Admin			Age at the time	VIS Form Given			Manuf Abbr*	Lot Number	Dose	Admin Site**	Route	VFC ☐	Provider Initials*** or Outside Provider
	Mo	Day	Yr		Type	Mo	Yr							
PPV23					PPV						LA RA	IM SQ		
PPV23					PPV						LA RA	IM SQ		
Hepatitis A					Hep A						LT RT LA RA	IM		
Hepatitis A					Hep A						LT RT LA RA	IM		
Influenza					Flu						LT RT LA RA	IM		
Influenza					Flu						LT RT LA RA	IM		

*** Manufacturers: M = Merck; A = Aventis Pasteur; W = Wyeth; G = GlaxoSmithKline**
**** Sites: LT = Left Thigh, RT = Right Thigh, LA = Left Arm, RA = Right Arm**