

Immunization Record and History

PATIENT NAME (Last Name, First Name, Middle Initial)			NUMBER
BIRTHDATE	<input type="checkbox"/> Male <input type="checkbox"/> Female	KNOWN REACTIONS TO VACCINES/ALLERGIES	PRACTICE NAME/ADDRESS
VACCINES FOR CHILDREN (VFC) ELIGIBILITY (check one) <input type="checkbox"/> CHDP/Medi-Cal eligible <input type="checkbox"/> No health insurance <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> (Only federally qualified and rural health centers) Health insurance does not cover IZs <input type="checkbox"/> Not eligible			

If a combination vaccine (e.g., DTP + Hib or HepB + Hib) is used, record dose in each section.

VACCINE Circle one	DATE GIVEN*	MANUFACTURER AND LOT NUMBER	ADMINISTERED BY	SITE** VIS I.D.†	VACCINE	DATE GIVEN*	MANUFACTURER AND LOT NUMBER	ADMINISTERED BY	SITE** VIS I.D.†
IPV/OPV 1					MMR 1				SC
IPV/OPV 2					MMR 2				SC
IPV/OPV 3					Hep B 1				IM
IPV/OPV 4					Hep B 2				IM
DTaP/DTP/ DT/Td 1				IM	Hep B 3				IM
DTaP/DTP/ DT/Td 2				IM	Varicella 1				SC
DTaP/DTP/ DT/Td 3				IM	Varicella 2				SC
DTaP/DTP/ DT/Td 4				IM	<input type="checkbox"/> Check here if patient had chickenpox and does not need vaccine.				
DTaP/DTP/ DT/Td 5				IM	Hep A 1				IM
Td Booster				IM	Hep A 2				IM
HIB 1				IM	Pneumo Conj 1				IM
HIB 2				IM	Pneumo Conj 2				IM
HIB 3				IM	Pneumo Conj 3				IM
HIB 4				IM	Pneumo Conj 4				IM

TB SKIN TESTS

DATE GIVEN	TYPE	DATE READ	IMPRESSION
	<input type="checkbox"/> Mantoux <input type="checkbox"/> Other		<input type="checkbox"/> Negative <input type="checkbox"/> Positive (mm _____)
	<input type="checkbox"/> Mantoux <input type="checkbox"/> Other		<input type="checkbox"/> Negative <input type="checkbox"/> Positive (mm _____)
	<input type="checkbox"/> Mantoux <input type="checkbox"/> Other		<input type="checkbox"/> Negative <input type="checkbox"/> Positive (mm _____)

* **Date Given** is the date you gave the patient the Vaccine Information Statement (VIS) and you administered the vaccine.

** **Site:** Abbreviations are LD=left deltoid or left outer upper arm, LT=left thigh, RD=right deltoid or right outer upper arm, RT=right thigh. Proper route indicated by italics: IM=intramuscular, SC=subcutaneous.

† **VIS**—Vaccine Information Statement. Each VIS has an issue date in the lower corner; record the VIS issue date here. The VIS should be given to the patient/parent before each dose of vaccine is administered. Each VIS can be downloaded from www.cdc.gov/nip/publications/VIS.

Note: If you are recording a vaccine given elsewhere, record date dose was given, write in "elsewhere" or "transcribed" and/or name of provider.