



# VACCINE ADMINISTRATION RECORD

FOR THE PERSON GETTING IMMUNIZATIONS - PLEASE PRINT

{Write or stamp health department address to the right.}

Patient Name Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  Male  Female Age: \_\_\_\_ years \_\_\_\_ months

Address Type: (Check one or both)  Mailing  Home Address

Address: \_\_\_\_\_ Apt #: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Mother's Maiden Name (Optional): \_\_\_\_\_

Race: (Check all that apply)  American Indian/Alaskan Native  Asian  White  
 African American/Black  Native Hawaiian/Pacific Islander

Ethnicity: Hispanic?  Yes  No  Unknown

Spoken Language: \_\_\_\_\_ Written Language: \_\_\_\_\_

Medicaid Number: \_\_\_\_\_ Social Security Number: (Optional) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Would you like this in an alternate format (e.g. large print, read to you)?  Yes  No If yes, note your request: \_\_\_\_\_

I have received this clinic's HIPAA Notice of Privacy Practices information sheet.

I understand that Social Security Numbers are used to match immunization information received from multiple sources. Providing a Social Security Number will help make sure my immunization record is accurate and up-to-date and help prevent overuse of vaccines. I understand that refusing to provide my Social Security Number will not affect the services I receive today or in the future.

I have received, read and had my questions answered about the Vaccine Information Statement(s) for the shots to be given. I request that the shot(s) be given to me or the person named above, for whom I am responsible. My relationship to the patient is \_\_\_\_\_ (e.g. Mother, Father, Guardian). I also allow the release of any information needed to process insurance claims and request payment of medical benefits. I have given a copy of my current insurance card and allow the Oregon Department of Human Services to use and release this information to bill for received vaccines.

Print Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

### SCREENING QUESTIONS BEFORE IMMUNIZATIONS ARE GIVEN (PLEASE CHECK THE YES OR NO BOX)

The questions below will help us decide which vaccines may be given today. If you need help with these questions, please ask the clinic staff to help you.

1. Is the client sick today?..... Yes  No
2. Does the client have allergies to medicines, foods, latex or vaccines?..... Yes  No
3. Has the client had a bad reaction to a vaccination?..... Yes  No
4. Has the client had a seizure or a brain problem?..... Yes  No
5. Does the client have cancer, leukemia, AIDS or other immune system problems?..... Yes  No
6. Has the client taken cortisone, prednisone or other steroids, anti-cancer drugs, or had radiation treatments in the past 3 months?..... Yes  No
7. Has the client received any blood or blood products, or been given a medicine called Immune Globulin (IG) in the past year?..... Yes  No
8. Is the client pregnant or is there a chance she could become pregnant in the next month?.. Yes  No
9. Has the client received any vaccines in the past 4 weeks?..... Yes  No
10. Has the client ever fainted after injections in the past?..... Yes  No
11. Has the client had chicken pox disease?..... Yes  No  
If yes, give date or estimated date of disease: \_\_\_\_\_
12. Are you or your child enrolled in Women, Infants and Children (WIC) Program?..... Yes  No  
If no, would you like to be referred to the WIC Program?..... Yes  No



# VACCINE ADMINISTRATION RECORD (VAR)

FOR THE PERSON GETTING IMMUNIZATIONS. TO BE COMPLETED BY CLINICAL STAFF.

IRIS State ID: \_\_\_\_\_ Local ID: \_\_\_\_\_  
 Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ One-time only:

Not Given Code	Vaccine (Circle type given, if indicated)	Dose #	Brand Name (Circle one used if there's a choice)	RN Init.	Lot Number	Expiration Date	Manufact	Dose Amt. (ML)	Vaccine Inject. Code	Vaccine Eligib. Code	VIS Date
	DTaP		Infanrix® Tripedia® Daptacel®				GSK sanofi sanofi	0.5			
	DTaP-HepB-IPV		Pediarix®				GSK	0.5			
	Hep A (Peds)		Vaqta® Havrix®				Merck GSK	0.5			
	Hep A (Adult)		Vaqta® Havrix®				Merck GSK	1.0			
	Hep B (Peds/Adoles.)		Recombivax® Engerix®				Merck GSK	0.5/1			
	Hep B (Adult)		Recombivax® Engerix®				Merck GSK	1.0			
	Hep A-Hep B		Twinrix®				GSK	1.0			
	Hib		ActHib®				sanofi	0.5			
	Hib (PRPOMP)		PedVax®				Merck	0.5			
	Hib (PRPOMP)-Hep B		Comvax®				Merck	0.5			
	HPV		Gardasil®				Merck	0.5			
	Influenza Live		FluMist™				MedImm				
	Influenza (split)										
	IPV		IPOL®				sanofi	0.5			
	MCV4 (Mening Conj)		Menactra®				sanofi	0.5			
	MPSV4 (Mening Poly)		Menomune®				sanofi	0.5			
	MMR		MMR II®				Merck	0.5			
	MMR-V		ProQuad®				Merck	0.5			
	PCV7 (Pneumo Conj)		Prevnar®				Lederle	0.5			
	PPV23 (Pneumo Poly)		Pneumovax®				Merck	0.5			
	Rotavirus (Pentavalent)		RotaTeq®				Merck	2.0 PO			
	Td/Td (PF)/Td B		Decavac™				sanofi	0.5			
	Tdap		Boostrix® Adacel™				GSK sanofi	0.5			
	Varicella		Varivax®				Merck	0.5			
	Zoster		Zostavax®				Merck	0.5			

PPD Test	Reason Given Code	Lot # and Manufacturer	Inject. Code	RN Init.	MM Results	Date Read	Read By
					_____ Mm		

Vaccine Administrator Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_  
 Vaccine Administrator Signature\*: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

\*Use this 2nd signature line if more than one person gave immunizations to client.

Notes: \_\_\_\_\_