

1. Last Name First Name MI

2. Patient Number

3. Date of Birth  
 Month Day Year

4. Race  1. White  2. Black Ethnicity: Hispanic Origin?  
 3. Am. Indian/Alaskan Native  1. Yes  2. No  
 4. Asian/Pacific Islander  5. Other:

5. Sex  1. Male  2. Female

6. County of Residence

N.C. Department of Health and Human Services  
 Division of Public Health  
 Immunization Branch

# Vaccine Administration Record

\*I/parental designee have received the "Vaccine Information Statements" (VIS) about the disease(s) and vaccine(s). I have had a chance to review the VIS(s) and to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and request the vaccine(s) indicated below be given to me or the person named above for whom I am authorized to make this request.

Eligibility Status <sup>1</sup>	Vaccine Administered (circle one)	Date Admin.	Admin. Site <sup>2</sup> /Route <sup>3</sup>	Mfr. and Lot No.	Expiration Date	Contra-indication	*Consent or Authorization Signature	**Provider's Signature	Date Printed on VIS
	DTaP/DTP/DT #1								
	DTaP/DTP/DT #2								
	DTaP/DTP/DT #3								
	DTaP/DTP/DT #4								
	DTaP/DTP/DT #5								
	Hib/DTP-HIB #1								
	Hib/DTP-HIB #2								
	Hib/DTP-HIB #3								
	Hib/DTP-HIB #4								
	IPV/OPV #1								
	IPV/OPV #2								
	IPV/OPV #3								
	IPV/OPV #4								
	HBIG***								
	Hep B #1								
	Hep B #2								
	Hep B #3								
	MMR/MR #1								
	MMR/MR #2								
	Varicella #1								
	Varicella #2								
	PCV #1								
	PCV #2								
	PCV #3								
	PCV #4								
	Td #1								
	Td #2								
	Td #3								
	PPV23 #1								
	PPV23 #2								
	Influenza								
	Influenza								
	Hep A #1								
	Hep A #2								
	RV #1								
	RV #2								
	RV #3								
	Tdap								
	Meningococcal								
	HPV #1								
	HPV #2								
	HPV #3								

## Vaccine Administration Record

Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
(Last) (First) (Middle) Mo. Day Year

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Eligibility Status <sup>1</sup>	Vaccine Administered <small>(circle one)</small>	Date Admin.	Admin. Site <sup>2</sup> / Route <sup>3</sup>	Mfr. and Lot No.	Expiration Date	Contra-indication	*Consent or Authorization Signature	**Provider's Signature	Date Printed on VIS

**Allergies, TB Skin Test, Notes:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

<sup>1</sup>I am authorized by the parent, guardian, or person standing in loco parentis of the above-named child to obtain needed immunizations for the child.  
<sup>\*\*</sup>I have asked about immunizations and prior reactions. According to informant, none have occurred.  
<sup>\*\*\*</sup>An infant receiving HBIG should be evaluated for hepatitis B vaccine (Engerix 10 mcg/0.5ml OR Recombivax 5 mcg/0.5ml) within 12 hours of birth, and at and 6 months of age.

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| <p><b><sup>1</sup>Eligibility Status:</b> A – American Indian /Alaskan Native<br/>                 M – Medicaid<br/>                 N – Not Insured<br/>                 U – Underinsured (insurance does not cover full cost of immunizations)<br/>                 H – NC Health Choice for Children<br/>                 I – Insured</p> | <p><b><sup>2</sup>Admin. Site:</b> RA = Right Arm<br/>                 LA = Left Arm<br/>                 RT = Right Thigh<br/>                 LT = Left Thigh</p> <p><b><sup>3</sup>Admin. Route:</b> IM = Intramuscular<br/>                 SC = Subcutaneous<br/>                 Oral</p> |
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**Purpose:** To document vaccines administered.

**Preparation:** Update demographic information and complete at each vaccine administration.

**Directions:** Complete all requested information for each vaccine administered.

**Distribution:** Health Care Provider will maintain Vaccine Administration Record in individual's medical record.

**Disposition:** This form is to be retained in accordance with the *Records Retention and Disposition Schedule* of medical records as issued by the NC Division of Archives and History.

**Ordering Information:** Additional forms may be ordered from:  
 Division of Public Health – Immunization Branch  
 NC Department of Health and Human Services  
 1917 Mail Service Center  
 Raleigh, NC 27699-1917  
 Phone (877) 873-6247  
 FAX (800) 544-3058