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 Mo	Day	Yr	Age at the time	VIS Form Given Type	Mo	Yr	Manuf Abbr*	Lot Number	Dose	Admin Site	Route	VFC ✔	Provider Initials*** or Outside Provider Name
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 DTaP-IPV					DTP Polio					0.5cc	LA RA	IM		
Td Tdap					Td Tdap					0.5cc	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		
DTaP - IPV - Hib					DTP Polio Hib					0.5cc	LT RT LA RA	IM		
DTaP - IPV - Hib					DTP Polio Hib					0.5cc	LT RT LA RA	IM		
DTaP - IPV - Hib					DTP Polio Hib					0.5cc	LT RT LA RA	IM		
DTaP - IPV - Hib					DTP Polio Hib					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					MMR					0.5cc	LA RA	SQ		
MMR					MMR					0.5cc	LA RA	SQ		
MMRV					MMR Var					0.5cc	LA RA	SQ		
Varicella					Var					Vial	LA RA	SQ		
Varicella					Var					Vial	LA RA	SQ		

*** Manufacturers: M = Merck; S = Sanofi Pasteur; P = Pfizer; G = GlaxoSmithKline; N = Novartis**

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

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 Mo	Day	Yr	Age at the time	VIS Form Given Type	Mo	Yr	Manuf Abbr*	Lot Number	Dose	Admin Site**	Route	VFC ✔	Provider Signature or Outside Provider
PCV13					PCV					0.5cc	LT RT LA RA	IM		
PCV13					PCV					0.5cc	LT RT LA RA	IM		
PCV13					PCV					0.5cc	LT RT LA RA	IM		
PCV13					PCV					0.5cc	LT RT LA RA	IM		
Rotavirus					Rota							**PO**		
Rotavirus					Rota							**PO**		
Rotavirus					Rota							**PO**		
Hepatitis A					Hep A						LT RT LA RA	**IM**		
Hepatitis A					Hep A						LT RT LA RA	**IM**		
HPV					HPV						**LA RA**	**IM**		
HPV					HPV						**LA RA**	**IM**		
HPV					HPV						**LA RA**	**IM**		
MCV4					Mening						LT RT LA RA	**IM**		
MPSV4					Mening						LT RT LA RA	**SQ**		
Influenza					Flu						LT RT LA RA	**IM**		
Influenza					Flu						LT RT LA RA	**IM**		
PPV23					PPV						**LA RA**	**IM SQ**		
PPV23					PPV						**LA RA**	**IM SQ**		

Tuberculin Test

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

*** Manufacturers: M = Merck; S = Sanofi Pasteur; P = Pfizer; G = GlaxoSmithKline; N = Novartis**
**** Sites: LT = Left Thigh, RT = Right Thigh, LA = Left Arm, RA = Right Arm**