

1. Last Name	First Name	MI
2. Patient Number		
3. Date of Birth	Month	Day
4. Race	<input type="checkbox"/> 1. White <input type="checkbox"/> 2. Black <input type="checkbox"/> 3. Am. Indian/Alaskan Native <input type="checkbox"/> 4. Asian/Pacific Islander <input type="checkbox"/> 5. Other:	
5. Sex	<input type="checkbox"/> 1. Male <input type="checkbox"/> 2. Female	
6. County of Residence		

NC 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 ¹	Vaccine Administered (circle one)	Date Admin.	Admin. Site ² /Route ³	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 #1								
	Hib #2								
	Hib #3								
	Hib #4								
	IPV/OPV #1								
	IPV/OPV #2								
	IPV/OPV #3								
	IPV/OPV #4								
	Hep B #1								
	Hep B #2								
	Hep B #3								
	MMR #1								
	MMR #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 #1								
	Meningococcal #2								
	HPV #1								
	HPV #2								
	HPV #3								

Vaccine Administration Record

Name: _____ DOB: ____/____/____
 (Last) (First) (Middle) Mo. Day Year

* 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 ¹	Vaccine Administered (circle one)	Date Admin.	Admin. Site ² /Route ³	Mfr. and Lot No.	Expiration Date	Contraindication	*Consent or Authorization Signature	**Provider's Signature	Date Printed on VIS
	Men B #1								
	Men B #2								

Allergies, TB Skin Test, Notes:

* 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.

** I have asked about immunizations and prior reactions. According to informant, none have occurred.

¹Eligibility Status: A – American Indian /Alaskan Native
 M – Medicaid
 N – Not Insured
 U – Underinsured (insurance does not cover any portion of the cost of the vaccine)
 H – NC Health Choice for Children
 I – Insured

²Admin. Site: RA = Right Arm
 LA = Left Arm
 RT = Right Thigh
 LT = Left Thigh
³Admin. Route: IM = Intramuscular
 SC = Subcutaneous
 Oral

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