Patient Information

(please print clearly and firmly/ *por favor lea cuidadsamente*)

DISTRICT OF COLUMBIA
IMMUNIZATION PROGRAM
VACCINE ADMINISTRATION RECORD

Provider Information

Name

Address

Telephone

Insurance Plan

Patient ID Number *Medicaid Number* *Social Security Number*

Ethnicity: □ Hispanic □ Non-Hispanic

Race: □ A □ AI □B □ PI □ W □ O

Sex/*Sexo*: □ Male □ Female

Name (Last, First, Middle)/ *Nombre(Apelido, Primer Nombre, y Segundo Nombre)*

Birth Date/ *Fecha de nacimiento*

Address/ *Direccion*

Apt#

City/ *Cuidad* State/*Est*

Zip/*C.postal*

Parent or Guardian/ *Parente o Tutor*

(h)/*casa* Telephone/*Telefono*

(w)/trabajo Telephone/*Telefono*

IMMUNIZATION INFORMATION (please read)

I have been given a copy and have read or had explained to me the information contained in the appropriate CDC Vaccine Information Materials (VIMs) about the vaccine(s) indicated below. I have had a chance to ask questions that were answered to my satisfaction. I believe that I understand benefits and risk of the indicated vaccines and ask that the vaccine(s) checked below be given to me or the person named above for whom I am authorized to make this request.I understand that this information may be stored in the DOH Immunization Program's Registry.

"Se me ha dado una copia y se ha leido o explicado la informacion contenida en los materiales informativios apropiados de vacunas de CDC acerca de la(s) vacuna(s) abajo indicada. He tenido la oportunidid de hacer preguntas que han sido contestadas a mi satisfaccion. Creo entender los beneficios y riesgos de las vacunas indicadas y pido que la(s) vacuna(s) marcada(s) abajo me sea dada a mi o a la persona nombrada arriba por quien yo estoy autorizado(a) para hacer esta peticion. Yo entiendo que esta informacion debe ser almacenada en el Registro Central de Immunizacion del Departamento de Salud/Vacunas del Distrito de Columbia".

	Vaccine & Dose Number	Pt's Age	Date Vaccine Given	Inj. Site	Signature of Provider (MD, RN)	Vaccine Source	Vaccine Mfr	Lot #	VIS Given/ Public. Date	Signature of Patient/ Parent / Guardian
CIRCLE ONE	DT/DTaP/Td/Tdap 1								□ /	
	DT/DTaP/Td/Tdap 2								□ /	
	DT/DTaP/Td/Tdap 3								□ /	
	DT/DTaP/Td/Tdap 4								□ /	
	DT/DTaP/Td/Tdap 5								□ /	
	DTaP-Hib 4								□ /	
CIRCLE ONE	Hib/DTaP-IPV-Hib 1								□ /	
	Hib/DTaP-IPV-Hib 2								□ /	
	Hib/DTaP-IPV-Hib 3								□ /	
	Hib/DTaP-IPV-Hib 4								□ /	
	Hib - Hep B 1								□ /	
	Hib - Hep B 2								□ /	
	Hib - Hep B 3								□ /	
	HepB 1								□ /	
	HepB 2								□ /	
	HepB 3								□ /	
	DTaP-HepB-IPV 1								□ /	
	DTaP-HepB-IPV 2								□ /	
	DTaP-HepB-IPV 3								□ /	
	IPV 1								□ /	
	IPV 2								□ /	
CIRCLE ONE	IPV 3								□ /	
	IPV/DTaP-IPV 4								□ /	
	MMR/MMRV 1								□ /	
	MMR/MMRV 2								□ /	
	Varicella 1								□ /	
	Varicella 2								□ /	
	Influenza 1								□ /	
	influenza 2								□ /	
CIRCLE ONE	PCV7/PPV23 1								□ /	
	PCV7/PPV23 2								□ /	
	PCV7/PPV23 3								□ /	
	PCV7/PPV23 4								□ /	
	Hepatitis A 1								□ /	
	Hepatitis A 2								□ /	
	HepA - HepB 1								□ /	
	HepA - HepB 2								□ /	
CIRCLE ONE	HepA - HepB 3								□ /	
	MCV4/MPSV4 1								□ /	
	Rotavirus 1								□ /	
	Rotavirus 2								□ /	
	Rotavirus 3								□ /	
	HPV 1								□ /	
	HPV 2								□ /	
	HPV 3								□ /	
	HBIG 1								□ /	

Chickenpox Disease: Yes □ No □ Disease Date Mo. _____ Yr. _____, Verified by _____

Revised 3/27/09