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
□ Male □ Female

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

Birth Date/ *Fecha de nacimiento*

Sex/Sexo

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 District of Columbia Immunization Information System (DOCIIS).

"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.	Vaccine 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								□ /	
	Hib / DTaP-IPV-Hib	1								□ /	
	Hib / DTaP-IPV-Hib	2								□ /	
	Hib / DTaP-IPV-Hib	3								□ /	
	Hib / DTaP-IPV-Hib	4								□ /	
	HepB	1								□ /	
	HepB	2								□ /	
	HepB	3								□ /	
	DTaP-HepB-IPV	1								□ /	
	DTaP-HepB-IPV	2								□ /	
	DTaP-HepB-IPV	3								□ /	
	IPV	1								□ /	
	IPV	2								□ /	
	IPV	3								□ /	
	IPV / DTaP-IPV	4								□ /	
	MMR / MMRV	1								□ /	
CIRCLE ONE	MMR / MMRV	2								□ /	
	Varicella	1								□ /	
	Varicella	2								□ /	
	IIV (Flu)	1								□ /	
	IIV (Flu)	2								□ /	
	LAIV	1								□ /	
	LAIV	2								□ /	
CIRCLE ONE	PCV13 / PPV23	1								□ /	
	PCV13 / PPV23	2								□ /	
	PCV13 / PPV23	3								□ /	
	PCV13 / PPV23	4								□ /	
	Hepatitis A	1								□ /	
	Hepatitis A	2								□ /	
	MCV4 / MPSV4	1								□ /	
	MCV4 / MPSV4	2								□ /	
	Rotavirus	1								□ /	
	Rotavirus	2								□ /	
	Rotavirus	3								□ /	
	HPV	1								□ /	
	HPV	2								□ /	
	HPV	3								□ /	
	Men B	1								□ /	
	Men B	2								□ /	
	Men B	3								□ /	
	HBIG									□ /	

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

DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH
IMMUNIZATION PROGRAM

INSTRUCTIONS FOR COMPLETING THE VACCINE ADMINISTRATION RECORD

PURPOSE: To document that information about immunizations has been provided to the patient/parent/guardian; to record vaccine information required by the Centers for Disease Control and Prevention (CDC) under the National Childhood Vaccine Injury Act of 1986; and to establish an efficient method of processing immunization services in a clinical setting. This sheet should be used in conjunction with the Vaccine Information Statements (VIS) provided by CDC.

EXPLANATION AND DEFINITIONS: Prior to giving an immunization, have the patient/parent/guardian read the appropriate vaccine information statement(s); or if they have difficulty reading, explain the information in the statements so that it is understood by them. Have them read (or read to them if necessary) the sections entitled "Who should get vaccine?" and screen the patient for current contraindications and precautions to immunization. *Please refer to the package insert for storage, handling, & administration Information.*

ITEM-BY-ITEM INSTRUCTIONS

PROVIDER INFORMATION: Write the *Name, Address,* and *Telephone Number* of the physician, clinic, or other medical provider from whom the patient is receiving immunizations. If a stamp is used, please stamp each copy of the Vaccine Administered Record.

PATIENT INFORMATION: Complete all items as appropriate. This information is entered into the DC Central Immunization Registry; limited patient information will be readily accessible without referencing a paper record. A copy of this VAR should be kept in the patient's permanent medical record.

Insurance Plan: Write name of insurance plan, i.e. Chartered, DC Medicaid, Unison, etc.

Patient ID Number: Write the number that the medical facility uses to uniquely identify the patient (e.g., medical record number, chart number).

Medicaid Number: If the patient is actively enrolled in the Medicaid program, write his/her Medicaid number. Do not use the parent's number.

Social Security Number: Write the patient's Social Security Number (SSN) on this line. Do not write the SSN of the parent/guardian or other person.

Name, Birth Date, Sex, Address, Apt #, City, State, Zip Code: Fill in completely.

Parent/Guardian: Write the name(s) of the patient's parent or guardian for patients who are un-emancipated minors under the age of 18 and for all patients under the custodial care of another individual.

Ethnicity: Please check the box indicating the patients ethnicity: Hispanic; Non-Hispanic

Race: Please check the letter(s) indicating the patients race: Asian (A); American Indian (AI); Black (B); Pacific Islander (PI); White (W); Other (O)

Home Telephone: Write the full home telephone number, including area code, of the patient or the patient's parent or guardian.

Work Telephone: Write the full work telephone number, including area code, of the patient or the patient's parent or guardian.

Patient's Age: Write the age of the patient, in either months or years, at the specific time of each vaccination.

Date Vaccine Given: Write the exact date that each specific vaccine was given. Write the date in the order: Month-Date- Year.

Injection Site: Write the 2-letter code for the site that each vaccine was administered. Use the Site Legend: LA= left arm; RA= right arm; LT= left thigh; RT= right thigh.

Name/ Title of Vaccinator: Name of person who actually administers the vaccine signs here. Use full signature and abbreviated title (e.g. RN, MD, MA).

IMMUNIZATION INFORMATION

(The following information is required by the CDC):

Vaccine: Select the correct line for the particular immunization to be administered; if necessary, circle the specific vaccine to be administered. Attach a copy or record of all previous immunizations given to the patient. Only copy information from the patient's documented immunization record.

Vaccines and Abbreviations:

DT - Pediatric diphtheria and tetanus toxoids	VZV - Varicella zoster vaccine (Chickenpox vaccine)
DTaP - Diphtheria, tetanus, and acellular pertussis vaccine	IIV – Inactivated Influenza Vaccine (Whole or split-virion influenza vaccine
DTaP-IPV-HIB- Diphtheria, tetanus, acellular pertussis, Polio and Hib combination vaccine	LAIV – Live Attenuated Influenza Vaccine
DTaP-HepB-IPV - Diphtheria, tetanus, acellular pertussis, Hepatitis B, & Polio combination vaccine	PCV13 - Pneumococcal conjugate vaccine (13 valent)
DTaP-IPV - Diphtheria, tetanus, acellular pertussis, and Polio combination vaccine	PPV23 – Pneumococcal Polysaccharide Vaccine (23 valent)
Hib - Haemophilus influenzae type b conjugate	Rotavirus - Rotavirus vaccine, live oral pentavalent
HepA –Hepatitis A vaccine	MPSV4 - Meningococcal polysaccharide vaccine
IPV - Enhanced inactivated polio vaccine	MCV4 – Meningococcal Conjugate Vaccine
Tdap - Adolescent/adult tetanus, diphtheria, and acellular pertussis	MenB – Meningococcal B Vaccine
Td - Adult tetanus and diphtheria toxoids	HPV – Human Papillomavirus Vaccine
MMR – Measles, mumps, and rubella	HBIG - Hepatitis B immune globulin
MMRV – Measles, mumps, rubella and Varicella combination vaccine	

VACCINE SOURCE: Evaluate the patient's method of payment for immunization services each time a vaccine is given. Using the following definitions, write the letter corresponding to the financial source of each vaccine dose in the Source column of the Record.

Vaccine Source Code	Description of Vaccine Source Code
Private (P)	Vaccine purchased using other than government funds (i.e., patient has insurance which covers immunization cost)
State (S)	Vaccine was purchased by the District of Columbia government
Federal Section 3/7 (F)	Vaccine was purchased by the Federal government's Section 317 grant
Vaccine for Children Program	If patient qualifies for VFC, indicate reason by selecting: *Medicaid* (M), if the patient is actively enrolled in the DC Medicaid program; *No Health Insurance (0),* if the patient is not covered by any type of health insurance policy; *VFC Under-insured (U),* if the patient has insurance, but it does not cover immunization costs, and the Medical provider is a Federally Qualified Health Center; or, American *Indian/Alaskan Native (A),* if the patient is a member of one of these ethnic groups.

Vaccine Manufacturer: Write the drug manufacturer by using the following abbreviations:
B = Bayer; C = Chiron; GSK = GlaxoSmithKline; M = Merck; MBL = Massachusetts Biological Labs; Ml = Medlmmune, Inc.; SP = Sanofi Pasteur; W = Wyeth; CSL = CSL Biotherapies; N = NOVARTIS, P = Pfizer

Lot Number: Write the lot number located on the vaccine package and follow the manufacturer's instructions for proper use.

VIS Given/Publication Date: Check the box of the Vaccine Information Statement (VIS) that corresponds to the vaccine being given. Write the publication date of the VIS given to the patient or parent/guardian.

Signature of Patient/Parent/Guardian: The patient or the patient's parent/guardian signs here for each dose and type of vaccine to be given and agrees to the statement "I have been given a copy ... at the top of the Immunization Information section.

Chickenpox Disease: Mark this box if the patient has a reliable history of Chickenpox Disease. Must include the month and year of the disease, and the name of the health care provider verifying disease history. Parental recall of chickenpox disease history is not acceptable.

Please attach/submit a copy of all immunization histories, including those given by other providers.

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