Vaccine Administration Record

Clinic Name & Address

Vaccines For Children (VFC) Eligibility Screening is required by federal mandate for individuals under 19 who receive state supplied vaccine

Circle # in VFC column to complete screening:

1= Medicaid/ Dr. Dynasaur
2= Alaskan Native or Native American
3= No Insurance
4= Insurance other than Medicaid /Not VFC Eligible

Patient Name: _____

Date of Birth: ____/____/____

By initialing next to each dose of vaccine administered, I acknowledge the following:
I have read or have had explained to me the information in the Vaccine Information Statement about the diseases and vaccines listed below. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and ask that the vaccine listed next to my initials be given to me (or to the person named above for whom I am authorized to make this request).

Parent/ Guardian Signature: _____

***** Route/Site Legend:** IM = Intramuscular SC = Subcutaneous PO = Oral RA = Right Arm LA = Left Arm RT = Right Thigh LT = Left Thigh

Vaccine Type	Date Vaccine Admin & VIS Given	VFC (circle one)	*** Route/Site (circle one)	Manufacturer & Lot Number	Vaccine Expiration Date	VIS Publication Date	Parents Initials	Vaccine Admin Signature
DTaP-Hep B-IPV #1		1 2 3 4	IM / RT RA LT LA					
DTaP-Hep B-IPV #2		1 2 3 4	IM / RT RA LT LA					
DTaP-Hep B-IPV #3		1 2 3 4	IM / RT RA LT LA					
Hib #1		1 2 3 4	IM / RT RA LT LA					
Hib #2		1 2 3 4	IM / RT RA LT LA					
Hib #3		1 2 3 4	IM / RT RA LT LA					
Hib #4		1 2 3 4	IM / RT RA LT LA					
PCV-7 #1		1 2 3 4	IM / RT RA LT LA					
PCV-7 #2		1 2 3 4	IM / RT RA LT LA					
PCV-7 #3		1 2 3 4	IM / RT RA LT LA					
PCV-7 #4		1 2 3 4	IM / RT RA LT LA					
DTaP / DT #1		1 2 3 4	IM / RT RA LT LA					
DTaP / DT #2		1 2 3 4	IM / RT RA LT LA					
DTaP / DT #3		1 2 3 4	IM / RT RA LT LA					
DTaP / DT #4		1 2 3 4	IM / RT RA LT LA					
DTaP / DT #5		1 2 3 4	IM / RT RA LT LA					
IPV #1		1 2 3 4	IM SC / RT RA LT LA					
IPV #2		1 2 3 4	IM SC / RT RA LT LA					
IPV #3		1 2 3 4	IM SC / RT RA LT LA					
IPV # 4		1 2 3 4	IM SC / RT RA LT LA					
Hep A #1		1 2 3 4	IM / RT RA LT LA					
Hep A #2		1 2 3 4	IM / RT RA LT LA					
Hep B (Birth Dose)								
Hep B # ___		1 2 3 4	IM / RT RA LT LA					
Hep B # ___		1 2 3 4	IM / RT RA LT LA					
Hep B # ___		1 2 3 4	IM / RT RA LT LA					

Vaccine Administration Record Continued

Patient Name: _____

Date of Birth: ____/____/____

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Vaccine Type	Date Vaccine Admin & VIS Given	VFC (circle one)	*** Route/Site (circle one)	Manufacturer & Lot Number	Vaccine Expiration Date	VIS Publication Date	Parents Initials	Vaccine Admin Signature
Rotavirus #1		1 2 3 4	PO / RT RA LT LA					
Rotavirus #2		1 2 3 4	PO / RT RA LT LA					
Rotavirus #3		1 2 3 4	PO / RT RA LT LA					
MMRV #1		1 2 3 4	SC / RT RA LT LA					
MMRV #2		1 2 3 4	SC / RT RA LT LA					
MMR #1		1 2 3 4	SC / RT RA LT LA					
MMR #2		1 2 3 4	SC / RT RA LT LA					
Varicella #1		1 2 3 4	SC / RT RA LT LA					
Varicella #2		1 2 3 4	SC / RT RA LT LA					
Varicella Disease	Date:	/ /	History:					
Tdap #1		1 2 3 4	IM / RT RA LT LA					
Td #1		1 2 3 4	IM / RT RA LT LA					
MCV4		1 2 3 4	IM / RT RA LT LA					
HPV #1		1 2 3 4	IM / RT RA LT LA					
HPV #2		1 2 3 4	IM / RT RA LT LA					
HPV #3		1 2 3 4	IM / RT RA LT LA					
Influenza		1 2 3 4	IM / RT RA LT LA					
Influenza		1 2 3 4	IM / RT RA LT LA					
Influenza		1 2 3 4	IM / RT RA LT LA					
Influenza		1 2 3 4	IM / RT RA LT LA					
Influenza		1 2 3 4	IM / RT RA LT LA					
Influenza		1 2 3 4	IM / RT RA LT LA					
Influenza		1 2 3 4	IM / RT RA LT LA					
Other Vaccines								
		1 2 3 4	IM SC / RT RA LT LA					
		1 2 3 4	IM SC / RT RA LT LA					
		1 2 3 4	IM SC / RT RA LT LA					
		1 2 3 4	IM SC / RT RA LT LA					
		1 2 3 4	IM SC / RT RA LT LA					
		1 2 3 4	IM SC / RT RA LT LA					

Vermont Department of Health
Immunization Program
108 Cherry Street, P.O. Box 70
Burlington, VT 05402-0070
802-863-7638 or 800-464-4343 ext. 7638 (in VT only)

VERMONT
DEPARTMENT OF HEALTH