Vaccine Administration Record

Patient's Name_______________________________________Phone Number (____)_______________
Last First

☐ Male ☐ Female Birth date ____ Age ____________
Month Day Year

Address ____
Street City State Zip Code

Do you have: ☐ Medicaid ☐ Nevada Check-up # ______________________ Type: HPNH NCSH

Do you have a medical doctor? ☐ yes ☐ no Name of doctor ____________________________

Select one: ☐ Native American or Alaskan Native ☐ Insurance that does not pay for vaccines
☐ No insurance ☐ Insurance that does pay for vaccines

Had Chicken Pox Disease: ☐ yes ☐ no

Did you bring your or your child's immunization record today? ☐ **Yes** ☐ **No**

It is important for you to have a personal record of your vaccinations. If you don't have a record card, ask your health care provider to give one to you. Bring this record with you every time you seek medical care. Make sure your health care provider records all your vaccinations on it. Your child will need this card to enter childcare, kindergarten, college, etc.

The following questions will help us to determine which vaccines may be given today. If a question is not clear, please ask the nurse to explain it.

IS THE PERSON RECEIVING THE VACCINE…	Yes	No	Don't Know
1. Sick today?	☐	☐	☐
2. Allergic to medications, food or any vaccine?	☐	☐	☐
3. Ever had a serious reaction after receiving a vaccine?	☐	☐	☐
4. Been diagnosed with cancer, leukemia, AIDS or any other immune system problem?	☐	☐	☐
5. Taking cortisone, prednisone, other steroids, anticancer drugs or x-ray treatments?	☐	☐	☐
6. Been given a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin during the past year?	☐	☐	☐
7. Had a seizure or a brain problem?	☐	☐	☐
8. Received any vaccinations or skin tests in the past four (4) weeks?	☐	☐	☐
9. **For girls/women 9 years and older:**			
Have you started menstruation (period)?	☐	☐	☐
Pregnant?	☐	☐	☐
Trying to get pregnant in the next 28 days?	☐	☐	☐
When was your last menstrual period? ______________________________			

Disclaimer

I have read or have had explained to me the information contained in the Vaccine Information Statement(s) about the disease(s) and the vaccine(s). I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated on the reverse side be given to me or to the person named above for whom I am authorized to make this request.

Signature of client (18 yrs. of age and older): ________________________________ Date:____________

Signature of parent or guardian: ________________________________ Date: ____________
(If client is under 18 yrs. of age)

COMPLETE TOP PART ON BACK (NAME & DOB) ➔

Patient's Name______________________________ Birth Date__________________
Last First Month Day Year

AREA BELOW FOR SNHD STAFF ONLY

Vaccine	Date Given	Dose #	Mfg & Lot #	Site*	Route **	VIS Date	Administered by (Name/Title)
DTaP				LA RA LT RT	IM	5/17/07	
DT				LA RA LT RT	IM	5/17/07	
Td				LA RA LT RT	IM	6-10-94	
Tdap **Adacel** **Boostrix**				LA RA LT RT	IM	7-12-06	
IPV				LA RA LT RT	IM SQ	1-1-00	
HIB				LA RA LT RT	IM	12-16-98	
MMR				LA RA LT RT	SQ	3-13-08	
C-Pox				LA RA LT RT	SQ	3-13-08	
MMRV **ProQuad**				LA RA LT RT	SQ	3-13-08 3-13-08	
Hep A				LA RA LT RT	IM	3-21-06	
Hep B				LA RA LT RT	IM	7-18-07	
Hep A/Hep B **Twinrix**				LA RA LT RT	IM	3-21-06 7-18-07	
Meningococcal **Menomune** **Menactra**				LA RA LT RT LA RA LT RT	SQ IM	1-28-08 1-28-08	
PCV7				LA RA LT RT	IM	9-30-02	
DTaP/IPV/ Hep B **Pediarix**				LA RA LT RT	IM	5/17/07 1-1-00 7-18-07	
Pneumonia				LA RA LT RT	IM SQ	7-29-97	
Rabies				LA RA LT RT	IM	1-12-06	
Rotavirus				ORAL	PO	4/12/06	
Flu				LA RA LT RT	IM IN	7-24-08	
Shingles **Zostavax**				LA RA LT RT	SQ	9-11-06	
HPV Gardasil				LA RA LT RT	IM	2-2-07	
Smallpox				LA RA LT RT	ID		
Newborn Screening							
Multi-Vaccine VIS						1-30-08	

**Site: RA (Right Arm), LA (Left Arm), RT (Right Thigh), LT (Left Thigh) **Route: IM (Intramuscular), SQ (*Subcutaneous)*

Record # ________________ Return Date: ______________ VIS Given ______________ ____________________
Clerk Clinician

Clinic Location: ☐ Main ☐ ELV ☐ NLV ☐ Hend ☐ Spring Valley ☐ ______________

Reviewed by: ________________________________ RN / LPN Date: ____________________

App BS 5/06 rev 8/28/08 leer\word\immunizations\vaccine administration record (VAR)