02/04/2008

North Carolina Immunization Registry

Organization: **NORTH CAROLINA IMMUNIZATION REGISTRY**

Site: **NORTH CAROLINA IMMUNIZATION REGISTRY**

Vaccine Administration Record

Information collected on this form will be used to document authorization for receipt of vaccine(s).

CHART NUMBER

Patient's Name (Last, First, Middle Initial)

	Date of Birth (mm/dd/yyyy)	Gender	Ethnicity (Check One)
		☐ Male ☐ Female	☐ Hispanic ☐ Non-Hispanic

Race (Check all that apply)
☐ American Indian or Alaskan Native
☐ Asian
☐ Native Hawaiian or Other Pacific Islander
☐ Black or African-American ☐ White ☐ Other Race ☐ Unknown

Mother's Maiden Name (Last, First, Middle Initial)

Eligibility Status (Check only one)
This section must be completed for children through age 18 given state-supplied vaccines.

☐ **American Indian /Alaskan Native**
☐ **Underinsured**
☐ **Refusal to give information**
☐ **Medicaid**
☐ **NC Health Choice**
☐ **Not applicable**
☐ **Not Insured**
☐ **Insured**

Date Last Verified (mm/dd/yyyy): _____/_____/_____

Name of Parent or Guardian Responsible for Patient (Last, First, Middle Initial)		Relationship to Patient	
Address		P.O. Box	
City	County	State	Zip Code
Email address (if applicable)	Home Telephone Number ( )	Work Telephone Number ( )	Extension
	Is reminder/recall contact allowed? ☐ Yes ☐ No	Would you like reminder/recall sent to you? ☐ Yes ☐ No	

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/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 to be given to me or the person named above for whom I am authorized to make this request.

SIGNATURE - Person to receive vaccine or person authorized to sign on the patient's behalf	Date Signed
X	

FOR OFFICE USE

Vaccine	Trade Name	Lot #	VIS Pub. Date	Date VIS Presented	Body Route	Body Site *	mL.
DTP/aP					IM	RV LV RD LD	
HepB					IM	RV LV RD LD	
Hib					IM	RV LV RD LD	
MMR					SC	RV LV RD LD	
Pneumo Conjugate 7					IM	RV LV RD LD	
Polio						RV LV RD LD	
Varicella					SC	RV LV RD LD	
Other							

*RV = Right Vastus Lateralis LV = Left Vastus Lateralis RD = Right Deltoid LD = Left Deltoid Subcutaneous injections are administered in the muscle "area".

SIGNATURE AND TITLE - Person Administering Vaccine	Date Vaccine Administered