1. Last Name First Name MI

2. Patient Number — H

3. Date of Birth Month Day Year

4. Race ☐ 1. White ☐ 2. Black ☐ 3. Am. Indian/Alaskan Native ☐ 4. Asian/Pacific Islander ☐ 5. Other:_____
Ethnicity: Hispanic Origin? ☐ 1. Yes ☐ 2. No

5. Sex ☐ 1. Male ☐ 2. Female

6. County of Residence

NC Department of Health and Human Services
Division of Public Health
Immunization Branch

Vaccine Administration Record

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

Eligibility Status[1]	Vaccine Administered *(circle one)*	Date Admin.	Admin. Site[2]/ Route[3]	Mfr. and Lot No.	Expiration Date	Contra-indication	*Consent or Authorization Signature	**Provider's Signature	Date Printed on VIS
	DTaP/DTP/DT #1								
	DTaP/DTP/DT #2								
	DTaP/DTP/DT #3								
	DTaP/DTP/DT #4								
	DTaP/DTP/DT #5								
	Hib #1								
	Hib #2								
	Hib #3								
	Hib #4								
	IPV/OPV #1								
	IPV/OPV #2								
	IPV/OPV #3								
	IPV/OPV #4								
	Hep B #1								
	Hep B #2								
	Hep B #3								
	MMR #1								
	MMR #2								
	Varicella #1								
	Varicella #2								
	PCV #1								
	PCV #2								
	PCV #3								
	PCV #4								
	Td #1								
	Td #2								
	Td #3								
	PPV23 #1								
	PPV23 #2								
	Influenza								
	Influenza								
	Hep A #1								
	Hep A #2								
	RV #1								
	RV #2								
	RV #3								
	Tdap								
	Meningococcal #1								
	Meningococcal #2								
	HPV #1								
	HPV #2								
	HPV #3								

Vaccine Administration Record

Name: _____DOB:__ __/__ __/__ __ __ __
(Last) (First) (Middle) Mo. Day Year

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

Eligibility Status[1]	Vaccine Administered *(circle one)*	Date Admin.	Admin. Site[2]/ Route[3]	Mfr. and Lot No.	Expiration Date	Contra-indication	*Consent or Authorization Signature	**Provider's Signature	Date Printed on VIS
	Men B #1								
	Men B #2								

Allergies, TB Skin Test, Notes:

* 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 have asked about immunizations and prior reactions. According to informant, none have occurred.

[1]Eligibility Status:
A – American Indian /Alaskan Native
M – Medicaid
N – Not Insured
U – Underinsured (insurance does not cover any portion of the cost of the vaccine)
H – NC Health Choice for Children
I – Insured

[2]Admin. Site:
RA = Right Arm
LA = Left Arm
RT = Right Thigh
LT = Left Thigh

[3]Admin. Route:
IM = Intramuscular
SC = Subcutaneous
Oral

Purpose: To document vaccines administered.

Preparation: Update demographic information and complete at each vaccine administration. Directions: Complete all requested information for each vaccine administered.

Distribution: Health Care Provider will maintain Vaccine Administration Record in individual's medical record.

Disposition: This form is to be retained in accordance with the *Records Retention and Disposition Schedule* of medical records as issued by the NC Division of Archives and History.

Form can be found at http://immunize.nc.gov/providers/ncip/pdf/vaccine_admin_record.pdf