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 |
|---|---|
| | |