Immunization Registry

Information About Person to Receive Vaccine *(please print)*

Patient's Medicaid Number:			Patient Social Security Number:		
Patient's Name: *Last*	*First*	*MI*	Birthdate	Sex	Race: AI / Phone #
Parent's Name: *Last*	*First*	*MI*	Mother's Social Security Number:		
Address: *Street*					
City	*County*		*State*	*Zip*	

Initial/Date once vaccinations have been entered into MIIX.

_____ *Initial*

_____ *Date*

For Clinic/Office Use Only

Eligibility Status — VFC: ☐ Uninsured ☐ Medicaid ☒ American Indian ☐ Underinsured *(insurance does not cover Immunizations)*
Insured: ☐ CHIP ☐ Private Insurance *(Insurance covers Immunizations)* ☐ Special Projects _____

VFC Pin#: 2cw01 Facility Name: CHC Date Vaccinated & VIS issued: ___/___/___

Pentacel ☐ DTaP ☐ DTap/IPV/Hib — Kinrix ☐ DTap/IPV — Pediarix ☐ DTap/IPV/HepB
Manufacturer and Lot Number
Injection Site ☐ *Right* ☐ *Left* ☐ *Arm* ☐ *Thigh* *Route:* ____
VIS Revision Date ___/___/___

IPV
Manufacturer and Lot Number
Injection Site ☐ *Right* ☐ *Left* ☐ *Arm* ☐ *Thigh* *Route:* ____
VIS Revision Date ___/___/___

MMR
Manufacturer and Lot Number
Injection Site ☐ *Right* ☐ *Left* ☐ *Arm* ☐ *Thigh* *Route:* ____
VIS Revision Date ___/___/___

PedvaxHIB ☐ Hib (PRP-OMP) — ActHIB ☐ Hib (PRP-T) — Hiberix ☐ Hib (PRP-T)
Manufacturer and Lot Number
Injection Site ☐ *Right* ☐ *Left* ☐ *Arm* ☐ *Thigh* *Route:* ____
VIS Revision Date ___/___/___

Comvax ☐ Hep B ☐ Hep B/Hib
Manufacturer and Lot Number
Injection Site ☐ *Right* ☐ *Left* ☐ *Arm* ☐ *Thigh* *Route:* ____
VIS Revision Date ___/___/___

☐ Varicella ☐ ProQuad MMRV
Manufacturer and Lot Number
Injection Site ☐ *Right* ☐ *Left* ☐ *Arm* ☐ *Thigh* *Route:* ____
VIS Revision Date ___/___/___

Prevnar (PCV13)
Manufacturer and Lot Number
Injection Site ☐ *Right* ☐ *Left* ☐ *Arm* ☐ *Thigh* *Route:* ____
VIS Revision Date ___/___/___

Hep A
Manufacturer and Lot Number
Injection Site ☐ *Right* ☐ *Left* ☐ *Arm* ☐ *Thigh* *Route:* ____
VIS Revision Date ___/___/___

☐ RotaTeq RV5 ☐ Rotarix RV1
Manufacturer and Lot Number
☐ *Oral*
VIS Revision Date ___/___/___

☐ Gardasil HPV4 ☐ Gardasil 9 HPV9 ☐ Cervarix HPV2
Manufacturer and Lot Number
Injection Site ☐ *Right* ☐ *Left* ☐ *Arm* ☐ *Thigh* *Route:* ____
VIS Revision Date ___/___/___

☐ Menactra MCV4P ☐ Menveo MCV40 ☐ Menomune MPSV4
Manufacturer and Lot Number
Injection Site ☐ *Right* ☐ *Left* ☐ *Arm* ☐ *Thigh* *Route:* ____
VIS Revision Date ___/___/___

PPSV23
Manufacturer and Lot Number
Injection Site ☐ *Right* ☐ *Left* ☐ *Arm* ☐ *Thigh* *Route:* ____
VIS Revision Date ___/___/___

☐ Td ☐ Tdap
Manufacturer and Lot Number
Injection Site ☐ *Right* ☐ *Left* ☐ *Arm* ☐ *Thigh* *Route:* ____
VIS Revision Date ___/___/___

Other
Manufacturer and Lot Number
Injection Site ☐ *Right* ☐ *Left* ☐ *Arm* ☐ *Thigh* *Route:* ____
VIS Revision Date ___/___/___

Other
Manufacturer and Lot Number
Injection Site ☐ *Right* ☐ *Left* ☐ *Arm* ☐ *Thigh* *Route:* ____
VIS Revision Date ___/___/___

Prior to administration of the vaccine(s) checked above, a copy of the Vaccine Information Statement for each vaccine was provided to the client or representative of the child to whom the vaccine was administered. The clinic or his/her representative was given the opportunity to ask questions regarding the vaccine.

_____ /Time: _____
Signature of Vaccine Administrator/Title

Prior to administration of the vaccine(s) checked above, a copy of the Vaccine Information Statement for each vaccine was provided to me. I was given the opportunity to ask questions regarding the vaccine(s) and agree to its administration.

X _____
Signature of Vaccine Recipient or His/Her Parent or Representative