

NAME: _____

_____ Last First MI Birthday Age

ADDRESS: _____

_____ Street Phone

_____ City State Zip

"I have read or have had explained to me the Information in the Vaccine Information Statement (VIS) about the vaccine(s) that will be administered. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and ask that the vaccine(s) checked below be given to me or to the person named above for whom I am authorized to make this request."

In accordance with NOPP regulations: (please initial appropriate line)

_____ I authorize MCHD to send my child's immunization record to my physician _____

_____ I authorize MCHD to send my child's immunization record to _____ School District.

_____ I have been informed about the HIPAA Information

Signature of person to receive vaccine or person authorized to make request (Must be over 18).

X _____ Date: _____

Childhood Vaccine

Vaccine Administration Record

Vaccine	Dose #	Date Given	Manufacturer	Lot Number	Injection site	VIS
Ipv						1/1/00,1/30/08
DTaP						5/17/07, 1/30/08
Pediarix						1/30/08 *
Rotateq						08/28/08, 1/30/08
Hepatitis A						3/21/2006
Hepatitis B						7/18/07, 1/30/08
Hib						12/16/98, 1/30/08
Prevnar						12/09/08, 1/30/08
MMR						3/13/08
Varicella						3/13/08
Pentacel						05/17/07,01/30/08
HPV (Gardasil)						2/2/07
Tdap						11/18/08
Meningococcal						1/28/08
Flu						

Clinic/Office Address

Revised 01/29/09

skh/vaccines

Signature of Vaccine Administrator _____ RN

Public Aid

*Dtap 5/17/07, IPV 1/30/08, Hep B 7/18/07