

Dr. Joel and Carol Bower - SBHC Vaccine Administration Record

Patient's Name _____ Phone Number () _____

Last First

Male Female Birth date _____ Age _____

Month Day Year

Address _____

Street City State Zip Code

Do you have: Medicaid Nevada Check-up # _____ Type: HPNH NCSH

Select one: Native American or Alaskan Native Insurance that does not pay for vaccines
 No insurance Insurance that does pay for vaccines

Had Chicken Pox Disease: yes no Month/Year _____

Did you bring your or your child's immunization record today? Yes No

It is important for you to have a personal record of your vaccinations. If you don't have a record card, ask your health care provider to give one to you. Bring this record with you every time you seek medical care. Make sure your health care provider records all your vaccinations on it. Your child will need this card to enter childcare, kindergarten, college, etc.

The following questions will help us to determine which vaccines may be given today. If a question is not clear, please ask the nurse to explain it.

IS THE PERSON RECEIVING THE VACCINE...	yes	no	Don't Know
1. Sick Today?			
2. Allergic to medications, food, or any vaccine?			
3. Ever had a serious reaction after receiving a vaccine?			
4. Been diagnosed with cancer, leukemia, AIDS, or any other immune disorder?			
5. Taking cortisone, prednisone, other steroid, anticancer drugs or x-ray treatments?			
6. Been given a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin during the past year?			
7. Had a seizure or brain problem?			
8. Received any vaccinations or skin tests in the past four (4) weeks?			
9. For girls/women over 9 years of age: Pregnant? Trying to get pregnant in the next 28 days? When was your last menstrual period?			

Disclaimer

I have read or have had explained to me the information contained in the Vaccine Information Statement(s) about the disease(s) and the vaccine(s). I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated on the reverse side be given to me or to the person named above for whom I am authorized to make this request.

Signature: _____ Date: _____

Patient's Name: _____ DOB : _____

AREA Below for Health Center Staff Only

Vaccine	Date given	Dose #	Mfg & Lot #	Site *	Route **	VIS Date	Administered by:
DTap				LA RA	IM	5/17/07	
Td				LA RA	IM	6/10/94	
Tdap Boostrix				LA RA	IM	7/12/06	
IPV				LA RA	IM SQ	1/1/00	
MMR				LA RA	SQ	3/13/2008 S 1/15/03	
Varicella				LA RA	SQ	3/13/2008 S 1/10/07	
Hep A				LA RA	IM	3/21/06	
Hep B				LA RA	IM	7/18/07	
Menactra				LA RA	IM	1/28/08	
Flu				LA RA	IM	07/24/08	
HPV				LA RA	IM	2/2/07	
Hib				LA RA	IM	12/16/98	
PCV				LA RA	IM	9/30/02	
				LA RA	IM SQ		
				LA RA	IM SQ		

*Site: RA (Right Arm), LA (Left Arm), **Route: IM (Intramuscular), SQ (*Subcutaneous)

Record # _____ Return Date _____ VIS Given _____

Clerk

Clinician

Clinic Location: 400 N. Palo Verde Henderson, Nevada 89015

Vaccines for Children (VFC)

Children through 18 years of age who meet at least one of the following criteria are eligible for VFC vaccines.

1. Medicaid enrolled
2. Uninsured
3. American Indian/Alaskan Native
4. Underinsured

