

VACCINE ADMINISTRATION RECORD

I have read or have had explained to me the information on the Vaccine Information Statements for the immunizations listed below. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of these immunizations and request that the vaccine checked below be given to me or the person named below for whom I am authorized to make this request.

I hereby affirm that I am the person that I represent myself to be and that I stand in the relationship to the client as I have indicated.

Signature of person to receive vaccine or person authorized to make the request (parent or guardian):

➔ _____ Relationship to Child: _____ Date: _____

Identification Checked By _____ **(Initials)**

Information about person to receive vaccine (please print)

Name:	Last	First	M.I.	Sex F M	Birth Date	Age
Address:	Street	City	County	State	Zip	

Clinic ID: _____ Date Vaccinated: _____

GIVEN	VACCINE	MANUFACTURER/ EXPIRATION DATE	LOT NUMBER	SITE/RT	DOSE	RN NAME
	DTaP					
	Td OR Tdap Boostrix 10-18 Adacel 19-64					
	Dtap/IPV/HepB					
	Dtap/IPV					
	Hib					
	IPV					
	Prevnar					
	Hep B or Hep A					
	MMR or MMRV					
	Varicella (Chicken Pox)					
	Rotavirus					
	Menomune 2-10, > 55 Menactra 11-55					
	Human Papilloma Virus (HPV)					
	Other:					

- Tetanus and Diptheria (Td) **OR**
- Tdap – Boostrix – Adacel 11-08-2008
- Baby's First Vaccines 09-18-2008
- Hepatitis A 3-21-06
- Hepatitis B (HBVAX) 07-18-07
- Human Papillomavirus 02-02-07

- Measles/Mumps, Rubella
(MMR,Me,Mu,Ru,MR) 03-13-08
- Meningitis (Menactra) 01-28-08
- Varicella 03-13-08
- Polio (IPV) 01-01-00

- Diptheria, Tetanus and Pertussis
(DTP,DTaP) 05-17-07
- Prevnar 12-09-08
- Rotavirus 08/28/2008
- Haemophilus influenzae type b (Hib)12-16-98

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
PATIENT ELIGIBILITY SCREENING RECORD
VACCINES FOR CHILDREN (VFC) *PLUS* PROGRAM

Date: _____

Child: _____
Last Name First Name MI

Date of Birth: _____ Age: _____

Parent/Guardian/
Individual of Record: _____
Last Name First Name MI

Provider: Logan County Department of Public Health, 109 Third Street, Lincoln, IL 62656-0508

A record must be kept in the health care provider office that reflects the status of all children 18 years of age or younger, who receive immunization through the VFC *Plus* Program. The record may be completed by the parent, guardian or the individual of record, or by the health care provider. This same record may be used for all subsequent visits as long as the child's eligibility status has not changed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine.

The parent or guardian has stated that this child qualifies for vaccination through the federal Vaccines For Children (VFC) program because he or she (check only one box):

- A. Is enrolled in Medicaid _____
- B. Does not have health insurance _____
- C. Is American Indian or Alaskan Native _____

OR this child does not qualify for vaccination through the Vaccines For Children (VFC) program (unless the provider is a Federally Qualified Health Center or Rural Health Clinic); however, this child may be provided vaccine through the Illinois Vaccines for Children (VFC) *Plus* Program because he or she:

- D. Has health insurance that does not pay for vaccines (underinsured). _____

The above eligibility status information was provided by me to my child's health care provider.

Signature of Parent or Legal Guardian Date

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