

Health Department

Office Use Only SIIS#

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Patient Signature Date (mm/dd/yy) Nurse's Signature Date (mm/dd/yy)	Patient Signature	Date (mm/dd/vv)	Nurse's Signature			Date (mm.	/dd <u>/vv)</u>					

Print Name

VACCINE ADMINISTRATION PATIENT RECORD

LAST NAME:		FIRST NAME:		MI	MI DATE OF BIRTH:			
		DO NOT	WRITE BELOW	THIS LINE-FOR CI	LINIC USE ONL	Y		
CLINIC-PORTER COUNTY HEALTH DEPARTMENT: DATE VACCINATED AND DATE VIS PROVIDED TO PARENT / GUARDIAN / PATIENT Vaccine Charge: VacCare Self-Pay 317 Other								
VACCINE		DOSE	MANUFA	ACTURER & LOT NO.	ROUTE / SIT	E DATE OF VIS	CPT CODE	
Tdap / Td	0.5ml.				IM	4-1-2020 4-1-2020	90715 / 90714	
IPV	0.5ml.				Sub Q	10-30-19	90713	
MMR	0.5ml.				Sub Q	8-15-19	90707	
HEP A	1.0ml .				IM	7-20-16	90632	
HEP B	1.0ml				IM	8-15-19	90746	
VARICELLA	0.5ml.				Sub Q	8-15-19	90716	
Hep AB (Twi	nrix) 1.0ml.				IM	7-20-16 8-15-19	90636	
MCV4 0.5m	l.				IM	8-15-19	90734 /90733	
Men B – Bexse	ero 0.5ml.	_			—— ІМ	8-15-19	90620	
PPSV23	0.5ml.				IM	10-30-19	90732	
PCV13	0.5ml.	Γ			IM	10-30-19	90670	
INFLUENZA Product:	0.5ml.				IM	8-15-19	90686	
HPV 9	0.5ml.				IM	10-30-19	90651	
Shingrix	0.5 ml				IM	10-30-19	90750	
TYPHOID	0.5ml.				IM	10-30-19	90691	
YELLOW FEV	ER 0.5ml.				Sub Q	4-1-2020	90717	
RABIES	1.0ml.				IM	01-08-2020	90675	
Japanese Enc Under age 3					<u>IM</u> <u>IM</u>	8-15-19	90738	
Cholera					Oral	10-30-19		
Date	Nurse's A Nurse's Signature	uthorization		CHIRP Date		put Responsibilities JPP Date UP	P Initials	