

Health Department

Pediatric/Adolescent Vaccination Clinic Consent

- □ I am the patient's PARENT and give permission for the vaccines to be administered today.
- □ I am the legal guardian & have documents proving my guardianship for the child/minor to receive vaccines today.
- □ I am not the parent and I have written permission for the child/minor to receive vaccines today.
- I am a grandparent acting in a custodial capacity in the absence of the child's natural parents.

1. Is the child sick today? Please Explain: Image: Construction of the child have allergies to medications, food, or any vaccine? List: Image: Construction of the child have allergies to medications, food, or any vaccine? List: 3. Has the child have allergies to medications, food, or any vaccine? List: Image: Construction of the child have allergies to medications, food, or any vaccine? List: 4. Has the child have a serious reaction to a vaccine in the past? Image: Construction of the child have cancer, leukemia, HIV/AIDS, or any other immune system problem? Image: Construction of the constenergic tenent and the construction of the construction	LEASE PRINT Patient's Last Name:	First Name:		MI:	Date of Birth MMDDYYYY Age:					
Patient's Race ': "African American Caucasian U.S. State of Foreign Country of Birth: What Language is spoken at home? Patient's Race ': "African American Caucasian U.S. State of Foreign Country of Birth: What Language is spoken at home? Patient's Current Mailing Address: City: State ZIP Code: HomePrimary Phone Number: Mother Current Mailing Address: City: State ZIP Code: HomePrimary Phone Number: Father or Legal Guardian's Last Name: Mother First Name: Mil Made Name: Mother's Contact Phone Number: Father or Legal Guardian's Last Name: Father First Name: Mil Made Name: Father's Contact Phone Number: Patient has Medicald Guardian's Last Name: Father First Name: Mil Patient has Medical for advase pragma information below? Theck here If Private Insurance is Used & Read Disclosure Below? Medicald Number: Patient has Medical for advase pragma information below? The advase pragma Subject for advase of the part of the										
Patient's Race ': "African American Caucasian U.S. State of Foreign Country of Birth: What Language is spoken at home? Patient's Race ': "African American Caucasian U.S. State of Foreign Country of Birth: What Language is spoken at home? Patient's Current Mailing Address: City: State ZIP Code: HomePrimary Phone Number: Mother Current Mailing Address: City: State ZIP Code: HomePrimary Phone Number: Father or Legal Guardian's Last Name: Mother First Name: Mil Made Name: Mother's Contact Phone Number: Father or Legal Guardian's Last Name: Father First Name: Mil Made Name: Father's Contact Phone Number: Patient has Medicald Guardian's Last Name: Father First Name: Mil Patient has Medical for advase pragma information below? Theck here If Private Insurance is Used & Read Disclosure Below? Medicald Number: Patient has Medical for advase pragma information below? The advase pragma Subject for advase of the part of the	Listed under any alias or other name? If soil ast Name Used	First Name User	4.		Gender √	Physician's Name:				
Datient's Race ': DAfrican American Caucasian American Cau		First Name Used:				Thysiolans raine.				
Patient's Race Y: D'Alrien American Caucasian JAm. Indar/iskino D'Multiracial DOther Hispanic Patient's Current Mailing Address: City: State ZIP Code: HomePrimary Phone Number: Mother or Legal Guardian's Last Name: Mother First Name: MI Madden Name: Mother's Contact Phone Number: Father or Legal Guardian's Last Name: Father First Name: MI Madden Name: Mother's Contact Phone Number: Current Medical Coverage Check here if Private Insurance Is Used & Read Disclosure Below': Patient has Medicaid (indexe program information below) Check here if Private Insurance Is Used & Read Disclosure Below': Medicaid Number: Patient has Medicaid (indexe program information below) Check here if Private Insurance Is Used & Read Disclosure Below': Program Number: Policy Number: Policy Number: Policy Number: Program Number: Policy Number: Policy Number: Policy Number: Policy Holder's Full Name: Insurance Sources the prosen and context work of Britts: Insurance Company Name: Policy Holder's Full Name: Individer's Data of Britts: Insurance Sources the program information and context work of Britts: Insurance Sources the program is the program program is the program is the program is the program i				11.						
Patient's Current Mailing Address: City: State ZIP Code: Home/Prinary Phone Number: Mother or Legal Guardian's Last Name: Mother First Name: MI Madden Name: Mothar's Contact Phone Number: Father or Legal Guardian's Last Name: Father First Name: MI Midein Name: Father's Contact Phone Number: Patient has Medicald (indicate program information below) Father First Name: MI Midein Name: Father's Contact Phone Number: Patient has Medicald (indicate program information below) Check here if Private Insurance Is Used & Read Disclosure Below: "Witewand coverage's declared or program information below) The work of the state state is the state	Patient's Race ✓: □African American □ Caucasian	U.S. State of Fo	oreign Country of Birt	th:	vvnat Language is sp	oken at nome?				
Mother or Legal Guardian's Last Name: Mother First Name: MI Maiden Name: Mother's Contact Phone Number: Father or Legal Guardian's Last Name: Father First Name: MI Maiden Name: Mother's Contact Phone Number: Father or Legal Guardian's Last Name: Father First Name: MI Father's Contact Phone Number: Image: Contact Phone Number: Patient Mas Medicaid (indicate program information below) Image: Contact Phone Number: Father's Contact Phone Number: Image: Contact Phone Number: Program Number: Image: Contact Phone Number: Image: Contact Phone Number: Image: Contact Phone Number: Image: Contact Phone Number: Program Number: Image: Contact Phone Number: Image: Contact Phone Number: Image: Contact Phone Number: Image: Contact Phone Number: Patient is NOT Covered by any Medical Insurance (we may require patient) for the program scance be verified; Policy Number: Image: Contact Phone Number: Image: Contact Phone Number: Patient is NOT Covered by any Medications. Answers determine which vaccines the person named above cash or colory. V VS VS Image: Antice Contact Phone Number: Image: Contact Phone Number: Image: Contact Phone Number: Image: Contact Phone Number: Image: Contact Phone Number: Policy Number: <td>Am. Indian/Eskimo IMultiracial IOther IHispanic</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>	Am. Indian/Eskimo IMultiracial IOther IHispanic									
Father or Legal Guardian's Last Name: Father First Name: MI Father's Contact Phone Number; Current Medical Coverage Patient has Medicaid (indicate program information below) Check here if Private Insurance Is Used & Read Disclosure Below': Wedicaid Number: Program Number: Program Number: Program Number: Patient is Not Covered by any Medical Insurance (We may require payment atime of vaccinetant in eighbility for the programs cannot be wellfield) Patient is Not Covered by any Medical Insurance (We may require payment atime of vaccinetant of eighbility for the programs cannot be wellfield) Patient is American Indian or Eskimo Patient is American Indian or Eskimo Policy Number: Policy Number: Policy Number: Screening: Please answer all questions. Answers determine which vaccines the person named above can receive today. Yes N Is the child sick today? Please Explain: Screening: Please answer all questions, food, or any vaccine? List: Is the child have allergies to medication, food, or any vaccine? Screening: Please answer allergies to medications, food, or any vaccine? Screening: Please answer, leukemia, HIV/AIDS, or any other immune system problem? Soes the child have allergies to medications. Answers determine which vaccines the person named above can receive today. Yes N Boes the child have allergies to medications, food, or any vaccine? Soes the child have allergies to medications, foo	Patient's Current Mailing Address:	City:		State	ZIP Code:	Home/Primary Phor	e Numbe	er:		
Father or Legal Guardian's Last Name: Father First Name: MI Father's Contact Phone Number; Current Medical Coverage Patient has Medicaid (indicate program information below) Check here if Private Insurance Is Used & Read Disclosure Below': Wedicaid Number: Program Number: Program Number: Program Number: Patient is Not Covered by any Medical Insurance (We may require payment atime of vaccinetant in eighbility for the programs cannot be wellfield) Patient is Not Covered by any Medical Insurance (We may require payment atime of vaccinetant of eighbility for the programs cannot be wellfield) Patient is American Indian or Eskimo Patient is American Indian or Eskimo Policy Number: Policy Number: Policy Number: Screening: Please answer all questions. Answers determine which vaccines the person named above can receive today. Yes N Is the child sick today? Please Explain: Screening: Please answer all questions, food, or any vaccine? List: Is the child have allergies to medication, food, or any vaccine? Screening: Please answer allergies to medications, food, or any vaccine? Screening: Please answer, leukemia, HIV/AIDS, or any other immune system problem? Soes the child have allergies to medications. Answers determine which vaccines the person named above can receive today. Yes N Boes the child have allergies to medications, food, or any vaccine? Soes the child have allergies to medications, foo						() -				
Father or Legal Guardian's Last Name: Father First Name: MI Father's Contact Phone Number; Current Medical Coverage Patient has Medicaid (indicate program information below) Check here if Private Insurance Is Used & Read Disclosure Below': Wedicaid Number: Program Number: Program Number: Program Number: Patient is Not Covered by any Medical Insurance (We may require payment atime of vaccinetant in eighbility for the programs cannot be wellfield) Patient is Not Covered by any Medical Insurance (We may require payment atime of vaccinetant of eighbility for the programs cannot be wellfield) Patient is American Indian or Eskimo Patient is American Indian or Eskimo Policy Number: Policy Number: Policy Number: Screening: Please answer all questions. Answers determine which vaccines the person named above can receive today. Yes N Is the child sick today? Please Explain: Screening: Please answer all questions, food, or any vaccine? List: Is the child have allergies to medication, food, or any vaccine? Screening: Please answer allergies to medications, food, or any vaccine? Screening: Please answer, leukemia, HIV/AIDS, or any other immune system problem? Soes the child have allergies to medications. Answers determine which vaccines the person named above can receive today. Yes N Boes the child have allergies to medications, food, or any vaccine? Soes the child have allergies to medications, foo	Mother or Legal Guardian's Last Name	Mother First Nan	ne.	MI	Maiden Name:	Mother's Contact Ph	one Numbe	er.		
Current Medical Coverage Patient has Medicald (indicate program information below) Check here if Private Insurance Is Used & Read Disclosure Below': Medicaid Number: Winsurance coverage is declined or rejected after submission i will be your responsibility to pay any outstanding amounts due to use will will process your clim through a third party sorvice it is they who will determine that a lightly. There could be a delay as long as 60 plus days for final settlement. Program Number: Insurance Company Name: Policy Number: Organ Atoms of Weddial Insurance (We may require payment at time of vaccination of eligibility. There programs cannot be verified) Policy Number: Organ Number: Policy Number: Policy Number: Patient is NOT Covered by any Medical Insurance (We may require payment at time of vaccination of eligibility. There programs cannot be verified) Policy Number: Patient is American Indian or Eskimo Holder's Date of Birth: Screening: Please answer all questions. Answers determine which vaccines the person named above can receive today. V ES N 1. Is the child have allergies to medications, food, or any vaccine? List: 4 4 4 2. Does the child have a siter family member (father, mother, sibling) had a seizure or any brain disorder? 4 4 3. Does the child have a law optalete count or blood disorder? 4 4 4 <td>mother of Legal Quartian's Last Name.</td> <td colspan="2" rowspan="2">Mother First Name:</td> <td>1411</td> <td>Maidell Name.</td> <td></td> <td></td> <td><u>о</u>г.</td>	mother of Legal Quartian's Last Name.	Mother First Name:		1411	Maidell Name.			<u>о</u> г.		
Current Medical Coverage Patient has Medicald (indicate program information below) Check here if Private Insurance Is Used & Read Disclosure Below': Medicaid Number: Winsurance coverage is declined or rejected after submission i will be your responsibility to pay any outstanding amounts due to use will will process your clim through a third party sorvice it is they who will determine that a lightly. There could be a delay as long as 60 plus days for final settlement. Program Number: Insurance Company Name: Policy Number: Organ Atoms of Weddial Insurance (We may require payment at time of vaccination of eligibility. There programs cannot be verified) Policy Number: Organ Number: Policy Number: Policy Number: Patient is NOT Covered by any Medical Insurance (We may require payment at time of vaccination of eligibility. There programs cannot be verified) Policy Number: Patient is American Indian or Eskimo Holder's Date of Birth: Screening: Please answer all questions. Answers determine which vaccines the person named above can receive today. V ES N 1. Is the child have allergies to medications, food, or any vaccine? List: 4 4 4 2. Does the child have a siter family member (father, mother, sibling) had a seizure or any brain disorder? 4 4 3. Does the child have a law optalete count or blood disorder? 4 4 4 <td></td> <td></td> <td></td> <td>()</td> <td></td> <td></td>						()				
Patient has Medicaid (indicate program Information below) Check here if Private Insurance Is Used & Read Disclosure Below': Medicaid Number: ''f Insurance coursage is declined or rejected after submission It will be your responsibility to pay any otherminate alignbility. There could be a delay as long as 60 plus days for final settlement. Program Number: Insurance Company Name: Patient is NOT Covered by any Medical Insurance (We may require patient is American Indian or Eskimo Insurance Company Name: Patient is American Indian or Eskimo Policy Hulder's Full Name: Patient is American Indian or Eskimo Holder's Date of Birth: Screening: Please answer all questions. Answers determine which vaccines the person named above can receive today. Y HES N 1. Is the child had a serious reaction to a vaccine in the past? Insurance Company Name: Image: Company Name: <td< td=""><td>Father or Legal Guardian's Last Name:</td><td colspan="2">Father First Name:</td><td>MI</td><td>ļ</td><td>Father's Contact Ph</td><td>one Numbe</td><td>er;</td></td<>	Father or Legal Guardian's Last Name:	Father First Name:		MI	ļ	Father's Contact Ph	one Numbe	er;		
Patient has Medicaid (indicate program Information below) Check here if Private Insurance Is Used & Read Disclosure Below': Medicaid Number: ''f Insurance coursage is declined or rejected after submission It will be your responsibility to pay any otherminate alignbility. There could be a delay as long as 60 plus days for final settlement. Program Number: Insurance Company Name: Patient is NOT Covered by any Medical Insurance (We may require patient is American Indian or Eskimo Insurance Company Name: Patient is American Indian or Eskimo Policy Hulder's Full Name: Patient is American Indian or Eskimo Holder's Date of Birth: Screening: Please answer all questions. Answers determine which vaccines the person named above can receive today. Y HES N 1. Is the child had a serious reaction to a vaccine in the past? Insurance Company Name: Image: Company Name: <td< td=""><td></td><td colspan="2"></td><td></td><td></td><td>() -</td><td></td><td></td></td<>						() -				
Patient has Medicaid (indicate program Information below) Check here if Private Insurance Is Used & Read Disclosure Below': Medicaid Number: "If thesarance coursept is declined or rejected after submission It will be your responsibility to pay any other insurance Is NoT Covered by any Medical Insurance (We may require payment at the other of a debay as long as 60 plus days for final settlement. Program Number: Insurance Company Name: Patient is NOT Covered by any Medical Insurance (We may require payment at time of vaccination If eligibility for free programs cannot be verified) Policy Number: Patient is American Indian or Eskimo Holder's Full Name: Patient is American Indian or Clease explain: Holder's Date of Birth: Screening: Please answer all questions. Answers determine which vaccines the person named above can receive today. Y HES 1. Is the child had a serious reaction to a vaccine? List: Insurance Course or any brain disorder? I 2. Does the child have allergies to medications, food, or any vaccine? List: I I 3. Has the child as enious reaction to a vaccine in the past? I I 4. Has the child have allergies to medications, food, or any vaccine? List: I I 5. Does the child have alloring family member (father, mother, sibling) had a seizure or any brain disorder? I I 6. Does a parent, brother or a sister have a history of immune	Current Medical Coverage					l				
Medicaid Number: If insurance coverage is declined or rejected after submission it will be your responsibility to pay any outstanding amounts due us. We will process your claim through a third party service it is they who will determine thrat eighting. There could be a delay as borg as b			Check here i	f Privat	a Insurance is Lised &	Read Disclosure F	elow*:			
Medicaid Number: outstanding amounds due us. We will process your claim through a third party service it is they who will determine final eligibility. There could be a delay as 60 plus deys for final settlement. Program Number: Insurance Company Name: Policy Number: Patient is NOT Covered by any Medical Insurance (We may require payment at time of vaccination if eligibility for free programs cannot be verified) Policy Number: Patient is American Indian or I Eskimo Policy Holder's Full Name: Screening: Please answer all questions. Answers determine which vaccines the person named above can receive today. Y YES N 1. Is the child sick today? Please Explain: 2. Does the child have allergies to medications, food, or any vaccine? List: 3. Has the child have cancer, leukemia, HIV/AIDS, or any other immune system problem? 6. Does a parent, brother or a sister have a history of immune system problems? 7. Does the child have allergise on blood or blood products, or been given a medicine called immune (gamma) globulin in the past year? 6. Does a parent, brother or a sister have a history of immune system problems?										
Program Number: Insurance Company Name: Patient is NOT Covered by any Medical Insurance (We may require payment at time of vaccination if eligibility for free programs cannot be verified) Policy Number: Patient has insurance but vaccines are not covered Policy Holder's Full Name: Patient is American Indian or D Eskimo Holder's Date of Birth: Screening: Please answer all questions. Answers determine which vaccines the person named above can receive today. Y ES N 1. Is the child sick today? Please Explain: Image: Company State of State o	Medicaid Number:	outstanding amounts due us. We will process your claim through a third party service it is they v								
Dratem is mod vaccimation if eligibility for thee programs cannot be verified) Group Number: □ Patient is American Indian or □ Eskimo Policy Holder's Full Name: □ Patient is American Indian or □ Eskimo Holder's Date of Birth: Screening: Please answer all questions. Answers determine which vaccines the person named above can receive today. ✓ YES N 1. Is the child sick today? Please Explain: 2. Does the child have allergies to medications, food, or any vaccine? List: 3. Has the child a a serious reaction to a vaccine in the past? 4. Has the child have allergies to medications, food, or any other immune system problem? 5. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problems? 6. Does a parent, brother or a sister have a history of immune system problems? 9. In the past 3 months has the child taken cortisone, prednisone or other steroids for longer than 14 days? Has the child taken any cancer fighting treatments (radiation/chemotherapy) in the past year?	Program Number:									
□ Patient has insurance but vaccines are not covered Policy Holder's Full Name: □ Patient is American Indian or □ Eskimo Holder's Date of Birth: Screening: Please answer all questions. Answers determine which vaccines the person named above can receive today. YES 1. Is the child sick today? Please Explain:			Policy Number:							
□ Patient is American Indian or □ Eskimo Holder's Date of Birth: Screening: Please answer all questions. Answers determine which vaccines the person named above can receive today. YES N 1. Is the child sick today? Please Explain:	payment at time of vaccination if eligibility for free programs cannot be verified) Group Number:									
Screening: Please answer all questions. Answers determine which vaccines the person named above can receive today. YES 1. Is the child sick today? Please Explain: 2. Does the child have allergies to medications, food, or any vaccine? List: 3. Has the child had a serious reaction to a vaccine in the past? 4. Has the child or immediate family member (father, mother, sibling) had a seizure or any brain disorder? 5. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem? 6. Does a parent, brother or a sister have a history of immune system problems? 7. Does the child have a low platelet count or blood disorder? 8. In the past 3 months has the child taken cortisone, prednisone or other steroids for longer than 14 days? Has the child taken any cancer fighting treatments (radiation/chemotherapy) in the past year? 9. Has the child received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin in the past year? 10. Has the child/teen ever fainted? 11. Has the child/teen is female, is there a chance she is pregnant or could become pregnant during the next month?										
1. Is the child sick today? Please Explain:										
2. Does the child have allergies to medications, food, or any vaccine? List: Image: Constraint of the past paset of the past of the past of the past of										
3. Has the child had a serious reaction to a vaccine in the past? Image: Construction of the past past of the past of the past of the past of the past o	· ·									
4. Has the child or immediate family member (father, mother, sibling) had a seizure or any brain disorder? Image: Construct of the child have cancer, leukemia, HIV/AIDS, or any other immune system problem? 5. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem? Image: Construct of the co	• • • •							+		
5. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem? 6 6. Does a parent, brother or a sister have a history of immune system problems? 7 7. Does the child have a low platelet count or blood disorder? 8 8. In the past 3 months has the child taken cortisone, prednisone or other steroids for longer than 14 days? Has the child taken any cancer fighting treatments (radiation/chemotherapy) in the past year? 6 9. Has the child received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin in the past year? 6 10. Has the child received vaccinations in the past 4 weeks? If yes, list: 6 11. Has the child/teen ever fainted? 6 12. If the child/teen is female, is there a chance she is pregnant or could become pregnant during the next month? 6	· · · · · · · · · · · · · · · · · · ·									
6. Does a parent, brother or a sister have a history of immune system problems? Image: Constraint of the past of the past parent of the past parent of the past of the past of the past of the past parent of the past parent? Image: Constraint of the past parent paren										
7. Does the child have a low platelet count or blood disorder? Image: Constraint of the past 3 months has the child taken cortisone, prednisone or other steroids for longer than 14 days? Has the child taken any cancer fighting treatments (radiation/chemotherapy) in the past year? 9. Has the child received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin in the past year? 10. Has the child received vaccinations in the past 4 weeks? If yes, list: 11. Has the child/teen ever fainted? 12. If the child/teen is female, is there a chance she is pregnant or could become pregnant during the next month?										
8. In the past 3 months has the child taken cortisone, prednisone or other steroids for longer than 14 days? Has the child taken any cancer fighting treatments (radiation/chemotherapy) in the past year? 9. 9. Has the child received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin in the past year? 10. 10. Has the child received vaccinations in the past 4 weeks? If yes, list: 11. 11. Has the child/teen ever fainted? 12. 12. If the child/teen is female, is there a chance she is pregnant or could become pregnant during the next month? 11.										
(radiation/chemotherapy) in the past year? Image: constraint of the past year? 9. Has the child received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin in the past year? Image: constraint of the past year? 10. Has the child received vaccinations in the past 4 weeks? If yes, list: Image: constraint of the past year? Image: constraint of the past year? 11. Has the child/teen ever fainted? Image: constraint of the past year? Image: constraint of the past year? Image: constraint of the past year? 12. If the child/teen is female, is there a chance she is pregnant or could become pregnant during the next month? Image: constraint of the past year? Image: constraint of the past year?										
10. Has the child received vaccinations in the past 4 weeks? If yes, list: Image: Constraint of the past 4 weeks? If yes, list: 11. Has the child/teen ever fainted? Image: Constraint of the past 4 weeks? If yes, list: 12. If the child/teen is female, is there a chance she is pregnant or could become pregnant during the next month? Image: Constraint of the past 4 weeks?										
11. Has the child/teen ever fainted? Image: Comparison of the child/teen is female, is there a chance she is pregnant or could become pregnant during the next month? Image: Comparison of the child/teen is female, is there a chance she is pregnant or could become pregnant during the next month?										
12. If the child/teen is female, is there a chance she is pregnant or could become pregnant during the next month?										
** I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY FEES INCURRED NOT COVERED BY MY INSURANCE. **										
Consent to Vaccinate: Parent/Guardian must sign form for a child to receive vaccines. By signing										
below you are stating all information on this form is correct and that you had the opportunity to review our HIPAA Compliance Policy if desired. Note: We require previous vaccination records for all patients who received vaccines elsewhere.										
								-		
Parent/Guardian Signature Date (mm/dd/yy) Nurse's Signature Date (mm/dd	Parent/Guardian Signature	Date (mm/c	dd/yy) Nurse's Sigr	nature			Date (mm	n/dd/yy)		

VACCINE ADMINISTRATION PATIENT RECORD

LAST NAME:				FIRST NA	ME:			MIDDLE NAME:	
DATE OF BIRTH (mm	n/dd/yyyy):	AGE:		Contrain	dication:			-	
-	-							<u>v</u>	
DO NOT WRITE BELO CLINIC- PORTER COUNTY HEALTH DEPARTMENT: D 155 INDIANA AVE., VALPARAISO, IN 46383 G 3610 WILLOWCREEK RD, PORTAGE, IN 46368 (other):				DW THIS LINE-FOR CLINIC USE ONLY DATE VACCINATED AND DATE VIS PROVIDED TO PARENT / GUARDIAN / PATIENT Vaccine Charge: UXACare VFC Other					
VACCINE		DOSE	MANUFACTU	IRER & L	OT NO		ROUTE / SITE	DATE OF VIS	CPT CODE
PEDIARIX GSK		DOSL			.01 NO.			4-01-20 /8-15-19	
DTaP-HepB-IPV	0.5ml.						IM/	7-20-16/4-1-2020	90723
HIB	0.5 ml.						IM/	10-30-19/4-1-2020	90648
PCV ¹³ PPSV ²³	0.5ml						IM/	10-30-19/4-1-20 10-30-19	90670 90732
ROTAVIRUS GSK MERCK / RV5	/ RV1 1.0 ml 2.0 ml.						ORAL	10-30-19/4-1-2020	90681 90680
PENTACEL DTaP-Hib-I	PV 0.5ml						IM/	4-1-20 / 10-30-19 10-30-19/4-1-2020	90698
VARICELLA	0.5ml.						SUB QI	8-15-19	90716
MMR	0.5ml.						SUB Q/	8-15-19	90707
MMRV	0.5ml.						SUB QI	8-15-19	90710
HEPA	0.5ml.						IM/	7-20-16	90633
DTap Td Tdap	0.5ml.						IM/	4-1-20 / 4-1-2020 8-24-18 / 4-1-2020	90700 90714 90715
IPV	0.5ml.						SUB QI	10-30-2019/4-1-20	90713
HEP B	0.5ml.						IM/	8-15-19/4-1-2020	90744
Meningococcal A Menactra, Men							IM/	8-15-19	90734 90619
Meningococcal Bexsero	B 0.5ml						IM/	8-15-19	90620
INFLUENZA – IM FluMist	0.5ml						IM	8-15-19	VARIES Input Code:
HPV 9	0.5ml.						IM/	10-30-2019	90651
KINRIX DTap-IPV	0.5ml.						IM/	4-1-2020 / 10-30-19	90696
Date	Nurse's A Nurse's Signature	Authorization			CHIRP Date		Office Use Only: I CHIRP Initials	nput Responsibilities UPP Date	UPP Initials
					Crime Date			STT Date	