



NM VFC School Vaccine Administration Form



Form must be filled in completely.

Person receiving vaccine: **Please print in all capitals**

Last Name: _____ First Name: _____ MI: _____

Date of Birth: ____/____/____ Child's Age: _____ Mother's Maiden Name: _____
mm dd yyyy

Mother's First Name: _____

Sex: Male Female Ethnicity: Hispanic Non-Hispanic Race: American Indian White Asian African-American Other

Mailing Address: _____ City: _____ State: _____ Zip: _____

Responsible Person: _____ Relationship: _____
(Last Name) (First Name)

INSURANCE STATUS

For children 0-18 years of age, please mark appropriate category (Must Be Completed):

- No health insurance
- American Indian
- Medicaid/Salud – **place check mark next to plan:**
- ___ Blue Salud ___ Molina Salud
- ___ Lovelace Salud ___ Presbyterian Salud
- ___ Medicaid ___ Other _____

- Private/Commercial insurance:**
- Blue Cross Blue Shield
 - Lovelace
 - Presbyterian
 - United Healthcare
 - Other: _____
- (indicate company name)

Medicaid Salud # _____ Policy# _____

I have been given and have read, or have had explained to me, the information in the "Vaccine Information Statement(s)" for the disease(s) and vaccine(s) checked below. I understand the benefits and risks of the vaccines requested and also understand that I have the alternative to decline vaccines. I ask that the vaccines signed for below be given to the person named for whom I am authorized to make this request. I understand that some immunizations are given in a series over a period of time and that by signing this form I agree that the immunizations marked below will be given, including those needed to complete a series. I agree to report any problems that arise, and direct any questions I may have to the School Nurse. I also understand that I may request from the School Nurse procedures on how to lawfully discontinue a vaccine series once begun. I agree to allow information on immunizations given to the named person to be released to other medical care providers to avoid unnecessary vaccination or to ascertain immunization status. I also understand that my medical care provider may release this information to the state immunization registry (NMSIIS) unless I sign a document indicating my refusal.

Parent/guardian signature: _____ Date: _____

BELOW: FOR SCHOOL NURSE USE ONLY

Name of School: _____ VFC Pin #: _____

ENTER IN THE APPROPRIATE LOT #, DATE of VIS, and SITE/ROUTE FOR EACH VACCINE GIVEN

Vaccine <input type="checkbox"/> DTaP <input type="checkbox"/> MMR <input type="checkbox"/> DTaP.IPV <input type="checkbox"/> PCV <input type="checkbox"/> Hep A <input type="checkbox"/> Polio <input type="checkbox"/> Hep B <input type="checkbox"/> Rotavirus <input type="checkbox"/> Hib <input type="checkbox"/> Tdap <input type="checkbox"/> HPV <input type="checkbox"/> Varicella <input type="checkbox"/> Influenza <input type="checkbox"/> Other: <input type="checkbox"/> MCV4	Manufacturer <input type="checkbox"/> GSK <input type="checkbox"/> MedImmune <input type="checkbox"/> Merck <input type="checkbox"/> Novartis <input type="checkbox"/> Pfizer <input type="checkbox"/> Sanofi Pasteur Vaccinator:	Lot #: _____ Injection Site: _____ Date: _____ VIS Date: _____	Vaccine <input type="checkbox"/> DTaP <input type="checkbox"/> MMR <input type="checkbox"/> DTaP.IPV <input type="checkbox"/> PCV <input type="checkbox"/> Hep A <input type="checkbox"/> Polio <input type="checkbox"/> Hep B <input type="checkbox"/> Rotavirus <input type="checkbox"/> Hib <input type="checkbox"/> Tdap <input type="checkbox"/> HPV <input type="checkbox"/> Varicella <input type="checkbox"/> Influenza <input type="checkbox"/> Other: <input type="checkbox"/> MCV4	Manufacturer <input type="checkbox"/> GSK <input type="checkbox"/> MedImmune <input type="checkbox"/> Merck <input type="checkbox"/> Novartis <input type="checkbox"/> Pfizer <input type="checkbox"/> Sanofi Pasteur Vaccinator:	Lot #: _____ Injection Site: _____ Date: _____ VIS Date: _____
Vaccine <input type="checkbox"/> DTaP <input type="checkbox"/> MMR <input type="checkbox"/> DTaP.IPV <input type="checkbox"/> PCV <input type="checkbox"/> Hep A <input type="checkbox"/> Polio <input type="checkbox"/> Hep B <input type="checkbox"/> Rotavirus <input type="checkbox"/> Hib <input type="checkbox"/> Tdap <input type="checkbox"/> HPV <input type="checkbox"/> Varicella <input type="checkbox"/> Influenza <input type="checkbox"/> Other: <input type="checkbox"/> MCV4	Manufacturer <input type="checkbox"/> GSK <input type="checkbox"/> MedImmune <input type="checkbox"/> Merck <input type="checkbox"/> Novartis <input type="checkbox"/> Pfizer <input type="checkbox"/> Sanofi Pasteur Vaccinator:	Lot #: _____ Injection Site: _____ Date: _____ VIS Date: _____	Vaccine <input type="checkbox"/> DTaP <input type="checkbox"/> MMR <input type="checkbox"/> DTaP.IPV <input type="checkbox"/> PCV <input type="checkbox"/> Hep A <input type="checkbox"/> Polio <input type="checkbox"/> Hep B <input type="checkbox"/> Rotavirus <input type="checkbox"/> Hib <input type="checkbox"/> Tdap <input type="checkbox"/> HPV <input type="checkbox"/> Varicella <input type="checkbox"/> Influenza <input type="checkbox"/> Other: <input type="checkbox"/> MCV4	Manufacturer <input type="checkbox"/> GSK <input type="checkbox"/> MedImmune <input type="checkbox"/> Merck <input type="checkbox"/> Novartis <input type="checkbox"/> Pfizer <input type="checkbox"/> Sanofi Pasteur Vaccinator:	Lot #: _____ Injection Site: _____ Date: _____ VIS Date: _____

RA/IM (Right Arm/Intramuscular) LA/IM (Left Arm/Intramuscular) RT/IM (Right Thigh/Intramuscular) LT/IM (Left Thigh/Intramuscular) IN (Intranasal)

RA/SC (Right Arm/Subcutaneous) LA/SC (Left Arm/Subcutaneous) RT/SC (Right Thigh/Subcutaneous) LT/SC (Left Thigh/Subcutaneous) PO (By Mouth)