NEW MEXICO DEPARTMENT OF HEALTH

NM VFC Vaccine Administration Form – Part B

rev. 2/20/09

Please fill in form completely – **required** fields are marked with an asterisk (*)

New Mexico VFC Program

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

* Last Name: _____ * First Name: _____ MI: ___

* Date of Birth: ____/___/_____ (mm dd yyyy) * Mother's Maiden Name: _____ (Last Name) _____ (First Name)

* Mailing Address: _____ * City: _____

_____ * State: ___ * Zip: _____

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

INSURANCE STATUS

*** For children 0–18 years of age, please mark appropriate category (select only one):**

- ☐ No health insurance
- ☐ Underinsured: has commercial (private) health insurance but coverage does not include vaccines, covers selected vaccines, or caps vaccine coverage at a certain amount
- ☐ American Indian
- ☐ Medicaid/Salud – **place check mark next to plan**:
  - __Molina Medicaid/Salud
  - __Lovelace Medicaid/Salud
  - __Presbyterian Medicaid/Salud
  - __Blue Cross Blue Shield Medicaid/Salud
  - __United Healthcare Medicaid/Salud

Private/Commercial insurance:

- ☐ Blue Cross Blue Shield
- ☐ Lovelace
- ☐ Presbyterian
- ☐ United Healthcare
- ☐ Other: _____ (**indicate company name**)

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

BELOW: FOR CLINIC USE ONLY

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

Vaccine	Lot #	Date of VIS	Site/ Route (Codes below)	Vaccine	Lot #	Date of VIS	Site/ Route (Codes below)
DT				**HPV**			
DTaP				**Influenza**			
DTaP–Hep B–IPV (Pediarix)				**MCV4**			
DTaP–IPV–Hib (Pentacel)				**MMR**			
DTaP–IPV (Kinrix)				**MMRV**			
HBIG				**PCV7**			
Hep A				**Polio e–IPV**			
Hep A–Hep B (Twinrix)				**PPV23**			
Hep B/3 dose series				**Rotavirus/2d**			
Hep B/2 dose series				**Rotavirus/3d**			
Hep B–Hib (Comvax)				**Td**			
Hib/4 dose series				**Tdap**			
Hib/3 dose series				**Varicella**			

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)

* Vaccinator: _____ (**PRINT NAME**) * _____ (**SIGNATURE**) * _____ (**DATE OF SERVICE**) * VFC Pin #: _____

PLEASE NOTE:

- Areas with asterisks must be completed. **Forms missing information will be returned to provider for completion**.
- Direct NMSIIS entry of administered immunizations by VFC providers is required. Approved exceptions to this requirement should mail **completed** forms to: **NM Immunization Program, 1190 St. Francis Dr, Suite 1252, Santa Fe, NM 87505**