



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

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

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

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

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

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**