NEW MEXICO DEPARTMENT OF HEALTH

FORMULARIO PARA PONER VACUNAS INFANTILES (VFC NM) – PARTE B

New Mexico VFC Program

Por favor, llene el formulario completamente. Lo que es requisito está marcado con un asterisco (*) Rev.2/20/09

Persona que recibe la vacuna: **Escriba todo con letra mayúscula de molde**

* Apellido : _____ * Primer nombre: _____ MI: ___

* Fecha de nacimiento: ____/___/_____ *Nombre de soltera de su madre: _____
dia mes ano (Apellido) (Primer nombre)

* Dirección: _____ * Ciudad: _____

_____ * Estado: ___ * Código postal: _____

* Guardián: _____ *Relación/parentesco: _____
(Apellido) (Primer nombre)

SÓLO PARA USO DE LA CLÍNICA BELOW; FOR CLINIC USE ONLY

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

*** 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: _____ * _____ * _____ * 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**