



NM VFC Vaccine Administration Form – Part B rev. 7/23/10

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

* Mother's First Name: _____

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

*Mailing Address _____ *City _____ *State _____ *Zip code _____

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

INSURANCE STATUS

***Please mark appropriate category (Required):**

- No health insurance
- American Indian
- Medicaid/Salud – **place check mark next to plan:**
 - ___ Blue Cross Medicaid/Salud ___ Molina Medicaid/Salud
 - ___ Lovelace Medicaid/Salud ___ Presbyterian Medicaid/Salud
 - ___ Medicaid FFS ___ United Healthcare Medicaid/Salud

Medicaid # _____

Private/Commercial insurance:

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

Policy # _____

FOR CLINIC USE ONLY

*** ENTER THE APPROPRIATE TRADE NAME, 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 <input type="checkbox"/> Cervarix <input type="checkbox"/> Gardasil | | | |
| DTAP <input type="checkbox"/> Daptacel <input type="checkbox"/> Infanrix | | | | Influenza | | | |
| DTaP-HepB-IPV (Pediatrix) | | | | MCV <input type="checkbox"/> Menactra <input type="checkbox"/> Menveo | | | |
| DTaP-IPV-Hib (Pentacel) | | | | MMR | | | |
| DTaP-IPV (Kinrix) | | | | MMRV (ProQuad) | | | |
| HBIG | | | | PCV (Prenar) | | | |
| HEP A <input type="checkbox"/> Havrix <input type="checkbox"/> Vaqta | | | | Polio IPV | | | |
| HEP B <input type="checkbox"/> Engerix <input type="checkbox"/> Recombivax | | | | PPSV (Pneumovax) | | | |
| Hep A-Hep B (Twinrix) | | | | Rotavirus <input type="checkbox"/> Rotarix <input type="checkbox"/> RotaTeq | | | |
| Hep B-Hib (Comvax) | | | | Td (Decavac) | | | |
| Hib (ActHib) | | | | Tdap <input type="checkbox"/> Boostrix <input type="checkbox"/> Adacel | | | |
| Hib (Hiberix) | | | | Varicella (Varivax) | | | |
| Hib (PedvaxHib) | | | | | | | |

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)

Direct NMSIIS entry of vaccines administered is required for VFC participation.