

Program MCH / Immunization
Location

Prince George's County Health Department
Maryland

VACCINE ADMINISTRATION RECORD

Please print

Admission Date <table border="1"> <tr> <td> </td><td> </td><td> </td> <td> </td><td> </td><td> </td> <td> </td><td> </td><td> </td> </tr> <tr> <td colspan="3">Month</td> <td colspan="3">Day</td> <td colspan="3">Year</td> </tr> </table>										Month			Day			Year		
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Discharge Date <table border="1"> <tr> <td> </td><td> </td><td> </td> <td> </td><td> </td><td> </td> <td> </td><td> </td><td> </td> </tr> <tr> <td colspan="3">Month</td> <td colspan="3">Day</td> <td colspan="3">Year</td> </tr> </table>										Month			Day			Year		
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Client Name (Last) (First) (M.I.)		Record Number (Office Use Only)
Street Address Apartment Number		Date of Birth
City State	Age (Office Use Only)	Sex (circle one) Male Female
Zip Code	Are you Hispanic or Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Home Phone Work/Day/Contact Phone	Race Select one of the following races. If you are multiracial, check all that apply: <input type="checkbox"/> American Indian <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Other: _____ <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander	
Parent/Legal Guardian/Custodian Relationship to Client	Parent/Legal Guardian's Social Security No.	
Child's Doctor	Address of Doctor	

Please answer the following questions carefully and correctly. Depending on your answers and the previous immunization records you give us, your child will be immunized. You also assume the full responsibility for the control of your child.	CIRCLE ONE		COMMENTS
	YES	NO	
1. Is he/she well today?	YES	NO	
2. Does your child have any major medical problems?	YES	NO	
3. Is your child taking any medication? If yes, name the medication.	YES	NO	
4. Has he/she had any immunizations (shots) in the last 30 days?	YES	NO	
5. Has he/she received a blood transfusion or Gamma Globulin in the last 12 months?	YES	NO	
6. Does your child have severe allergies to: a) eggs b) Neomycin antibiotic c) yeast d) Thimerosal e) gelatin f) latex	YES	NO	
7. Has he/she ever had a convulsion (fit, shaking spell, falling-out, seizure)?	YES	NO	
8. Has he/she ever reacted to an immunization (shot) with: a. Shock or collapse or unconsciousness, or difficulty breathing immediately following the shot? b. Paralysis, seizures, change in consciousness within 15 days of immunizations (encephalopathy)? c. Temperature 105°F (40.5°C) or more within 2 days? d. Collapse or shock-like status within 2 days? e. Convulsions (seizures) with or without fever within 3 days? f. Persistent inconsolable crying lasting more than 3 hours, and occurring within 2 days?	YES	NO	
9. Has your daughter started menstrual (monthly) periods? If yes, please write date of last period.	YES	NO	
10. Is there any history of convulsions (fit, seizure) in brothers, sisters, mother or father?	YES	NO	
11. Does any household member have Hepatitis B, cancer, AIDS or is on chemotherapy or corticosteroids?	YES	NO	
12. Has your child ever had the chickenpox disease? If yes, indicate month/year: _____ / _____	YES	NO	
13. Is there any reason he/she should not be immunized today?	YES	NO	

Parent or Guardian Signature	Date
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**This child qualifies for vaccinations through the Maryland VFC (Vaccines) Program because he/she:
(Please check only one of the following boxes):**

- a. is covered by or enrolled in Medical Assistance (MAC, MA, HMO, Kids Court, PWC, etc.) OR
- b. does not have health insurance, OR
- c. Is Native American (American Indian) or Alaskan Native, OR
- d. has health insurance that does not cover (pay for) vaccines

Parent/Guardian Signature

CONSENT

- ♦ I have received the Vaccine Information Sheet and have read, or have had explained to me, information about the diseases and vaccines listed below.
- ♦ I have had a chance to ask questions that were answered to my satisfaction.
- ♦ I believe I understand the benefits and risks of the vaccine(s) cited, and ask that the vaccine(s) listed below be given to me or to the person named above for whom I am authorized to make this request.

Vaccine	Dose (Check <input type="checkbox"/> Box)						Date Given Mo/Day/Yr	Site	Initial Vaccine Administration	Parent/Guardian Signature
	1	2	3	4	5	6				
DT TD DTaP Tdap										
IPV										
Pneumococcal Conjugate										
Hib										
MMR										
Varicella										
Hep B										
MMR-V										
DTaP/Hep B/IPV										
Hep B/HIB										
Meningococcal Conjugate										
Influenza										
Hep A										
Pneumococcal Polysaccharide										
HPV										
Rotavirus										

Nurse's Notes										

Check if information given to client: MCHP Health care resources

Community Health Nurse Signature	Date	Vaccine Administrator Signature	Date
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