VACCINE ADMINISTRATION RECORD

I have been given a copy and have read or have had explained to me the Information in the "Vaccine Information Statement(s)" for the disease(s) and vaccine(s) checked 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) requested and ask that the vaccine(s) checked below be given to me or to the person named below for whom I am authorized to make this request.

❑ Tdap ❑ MCV ❑ HAV ❑ RV ❑ Flu ❑ DTaP ❑ HBV ❑ Hib

❑ IPV ❑ MMR ❑ PCV_7 ❑ Td ❑ VAR ❑ OTHER _____

Information about Person to receive vaccine (Please Print)					
Name: Last	First	M.I.		Birthdate	Age
Address: Street	City	County		State	Zip
Race/Ethnicity ❑ Caucasian ❑ African American ❑ Asian ❑ American Indian ❑ Hispanic ❑ Other _____					
❑ Medicaid ❑ Uninsured ❑ *Underinsured Physician _____					
Signature of person to receive vaccine or person authorized to make the request				Date	

* Underinsured = Have insurance that does not cover vaccines.

FH-24 Rev. 7/06 (24324)
(Previous version 4/01 should be used first)

FOR CLINIC/OFFICE USE

Clinic/Office Address: _____

Date Vaccine Administered: _____

Vaccine Manufacturer: _____

Vaccine Lot Number: _____

Site of Injection: _____

Signature of Vaccine Administrator: _____

Title of Vaccine Administrator: _____

Information statements used:

DTaP - 7/30/01	MMR - 1/15/03	Tdap - 7/12/06
HBV - 7/1101	PCV_7 - 9/30/02	RV - 4/12/06
HIB - 12/16/98	Td - 6/10/94	Flu current years
IPV - 1/1/00	VAR - 12/16/98	
HAV - 3/2/06	MCV - 10/7/05	