New Mexico VFC Vaccine Administration Form

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: ____/____/_____ mm/ dd/ yyyy

* Mothers Maiden Name: ______________________
* Mothers First Name: _________________________

Sex: ☐ Male ☐ Female

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Race: ☐African American ☐Asian ☐Alaskan Native ☐American Indian/Native American ☐White ☐Other

.

*Mailing Address: _________________________ *City: __________________ *State: __________*Zip Code: _______

*Cell Phone: _________________ * Home Phone: ________________ Email address: __________________________

*Responsible Person: ______________________ (Last Name) ____________________ (First Name) Relationship: _______________Signature ___________________

☐ **Remind Me:** I consent to vaccine reminders by email, text, phone call, or mail for the person receiving the vaccine.

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

☐ No Health Insurance
☐ American Indian/Native American
☐ Alaskan Native
☐ Centennial Care (Medicaid) **– place check mark next to plan:**
___Blue Cross Blue Shield ___Molina Healthcare
___United Healthcare ___Presbyterian Health Plan
Centennial Care (Medicaid) Policy #: __________________________

Private/Commercial Insurance:
☐ Blue Cross Blue Shield
☐ Presbyterian Health Plan
☐ United Health Care
☐ Other: __________________ Policy #____________________

FOR CLINIC USE ONLY

*** REQUIRED DOCUMENTATION: VACCINE, MANUFACTURER, LOT #, VIS EDITION DATE, SITE/ROUTE, DATE VACCINATED, DATE VIS PROVIDED, NAME AND TITLE OF VACCINATOR & CLINIC ADDRESS.**

Vaccine & Manufacturer	Lot #	VIS Edition Date	Site/Route (codes below)	Vaccine & Manufacturer	Lot #	VIS Edition Date	Site/Route (codes below)
DTAP ☐ Daptacel (Sanofi) ☐ Infanrix (GSK)				**HPV** ☐ Gardasil 9 (Merck)			
DTaP/IPV/Hib Pentacel (Sanofi)				**Influenza** ☐ FluMist (MedImmune) ☐ Fluzone (Sanofi) ☐ Fluarix (GSK)			
DTaP/HepB/IPV Pediarix (GSK)				**MenACWY** ☐ Menactra (Sanofi) ☐ Menveo (Novartis) **Men B** ☐ Bexsero (GSK) ☐ Trumenba (Pfizer)			
DT (Sanofi)				**MMR** MMRII (Merck)			
DTaP/IPV Kinrix (GSK)				**MMRV** ProQuad (Merck)			
HBIG HyperHEP B (Telecris)		**N/A**		**PCV** Prevnar 13 (Pfizer)			
HEP A ☐ Havrix (GSK) ☐ Vaqta (Merck)				**Polio** IPOL (Sanofi)			
HEP B ☐ Engerix (GSK) ☐ Recombivax (Merck)				**PPSV** Pneumovax (Merck)			
Hep A/Hep B Twinrix (GSK)				**Rotavirus** ☐ Rotarix (GSK) ☐ Rota Teq (Merck)			
Hep B/Hib Comvax (Merck)				**Td** Tenivac			
Hib ActHib (Sanofi)				**Tdap** ☐ Boostrix (GSK)			
Hib PedvaxHib (Merck)				**Varicella** Varivax (Merck)			

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: ______________________ ____________________ _______________ ___________ __________
(Print Name & Title) **(Signature)** **(Date Vaccinated)** **(Date VIS given)** **(VFC PIN #)**

CLINIC ADDRESS: ____
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*** DIRECT NMSIIS ENTRY OF VACCINES ADMINISTERED IS REQUIRED.**