DHS Oregon Department of Human Services

Vaccine Administration Record

for the person getting immunizations - please print

Write or stamp health department address here

Patient Name Last:_____First:_____Middle:_____

Date of Birth: _____/_____/____ Gender: ☐ Male ☐ Female Age: _____years _____ months

Address Type: (Check one or both) ☐ Mailing ☐ Home Address

Address:_____Apt #:_____City: _____ State:_____ Zip:_____

Phone Number: (__ __ __) __ __ __ - __ __ __ __ Mother's Maiden Name (Optional): _____

Race: (Check all that apply) ☐ American Indian/Alaskan Native ☐ Asian ☐ White ☐ Decline
☐ African American/Black ☐ Native Hawaiian/Pacific Islander

Ethnicity: Hispanic? ☐ Yes ☐ No ☐ Unknown ☐ Decline

Primary Language: _____

Medicaid Number:_____ Social Security Number*: (Optional) __ __ __ - __ __ - __ __ __ __

Would you like this in an alternate format (e.g. large print, read to you)? ☐ Yes ☐ No If yes, note your request: _____.

☐ I have received this clinic's HIPAA Notice of Privacy Practices information sheet.

I have received, read and had my questions answered about the Vaccine Information Statement(s) for the shots to be given. I request that the shot(s) be given to me or the person named above, for whom I am responsible. My relationship to the patient is _____ (e.g. Mother, Father, Guardian.). I also allow the release of any information needed to process insurance claims and request payment of medical benefits. I have given a copy of my current insurance card and allow the Oregon Department of Human Services to use and release this information to bill for received vaccines.

Print Name_____ Signature_____Date_____

Screening Questions Before Immunizations are Given (Please check the Yes or No box)

The questions below will help us decide which vaccines may be given today. If you need help with these questions, please ask the clinic staff to help you.

1. Is the client sick today? ..... ☐ Yes ☐ No
2. Does the client have allergies to medicines, foods, latex or vaccines? ..... ☐ Yes ☐ No
3. Has the client had a bad reaction to a vaccination? ..... ☐ Yes ☐ No
4. Has the client had a seizure or a brain problem? ..... ☐ Yes ☐ No
5. Does the client have cancer, leukemia, AIDS or other immune system problems? ..... ☐ Yes ☐ No
6. Has the client taken cortisone, prednisone or other steroids, anti-cancer drugs, or had radiation treatments in the past 3 months? ..... ☐ Yes ☐ No
7. Has the client received any blood or blood products, or been given a medicine called Immune Globulin (IG) in the past year? ..... ☐ Yes ☐ No
8. Is the client pregnant or is there a chance she could become pregnant in the next month? ..... ☐ Yes ☐ No
9. Has the client received any vaccines in the past 4 weeks? ..... ☐ Yes ☐ No
10. Has the client ever fainted after injections in the past? ..... ☐ Yes ☐ No
11. Has the client had chicken pox disease? ..... ☐ Yes ☐ No
    If yes, give date or estimated date of disease:_____
12. Are you or your child enrolled in Women, Infants and Children (WIC) Program? ..... ☐ Yes ☐ No
    If no, would you like to be referred to the WIC Program? ..... ☐ Yes ☐ No

*I understand that Social Security Numbers are used to match immunization information received from multiple sources. Providing a Social Security Number will help make sure my immunization record is accurate and up-to-date and help prevent overuse of vaccines. I understand that refusing to provide my Social Security Number will not affect the services I receive today or in the future.

DHS Oregon Department of Human Services

Vaccine Administration Record (VAR) - Adult (19 years and older)

for the person getting immunizations. To be completed by clinical staff.

IRIS State ID:_____ Local ID:_____ Client Name:_____

DOB: _____ Age: _____ One-time only: ☐

Not Given Code	Vaccine (Circle type given, if indicated)	Dose #	Brand Name (Circle one used if there's a choice)	RN Init.	Lot Number	Expiration Date	Manufact	Dose Amt. (ML)	Vaccine Inject. Code	Vaccine Eligib. Code	VIS Pub.Date
	Hep A (Adult)		Vaqta® Havrix®				Merck GSK	1.0			
	Hep B (Peds/Adult)		Recombivax® Engerix®				Merck GSK	0.5 1.0			
	Hep A-Hep B		Twinrix®				GSK	1.0			
	HPV		Gardasil® Cervarix®				Merck GSK	0.5 0.5			
	Influenza Live		FluMist™				MedImm	0.2			
	Influenza (split)							0.5			
	MCV4 (Mening Conj)		Menactra® Menveo®				sanofi Novartis	0.5 0.5			
	MPSV4 (Mening Poly)		Menomune®				sanofi	0.5			
	MMR		MMR II®				Merck	0.5			
	PPV23 (Pneumo Poly)		Pneumovax®				Merck	0.5			
	Td/Td (PF)/Td B		Decavac™				sanofi	0.5			
	Tdap		Boostrix® Adacel™				GSK sanofi	0.5			
	Varicella		Varivax				Merck	0.5			
	Zoster		Zostavax®				Merck	0.65			
	Other										

PPD Test	Reason Given Code	Lot # and Manufacturer	Inject. Code	RN Init.	MM Results	Date Read	Read By
					_____Mm		

Vaccine Administrator Signature:_____ Title:_____ Date:_____

Vaccine Administrator Signature*:_____ Title:_____ Date:_____

*Use this 2nd signature line if more than one person gave immunizations to client.

Notes: