NEW MEXICO DEPARTMENT OF HEALTH

New Mexico VFC Vaccine Administration Form

Please fill in form completely – required fields are marked with an asterisk (*)

Update: September 2019

Please provide the information for the person receiving the vaccine – print in all capitals.

***Last Name:**	***First Name:**		**MI:**
***Date of Birth:** _____ Month / Day / Year	***Mother's Maiden Name:**	***Mother's First Name:**	
***Mailing Address:**	***City:**	***State:** NM ***Zip:**	
***Cell Phone:**	***Home Phone:**	**Email:**	
***Sex:** ☐ Male ☐ Female	**Race:** ☐African American ☐Asian ☐White ☐American Indian/Alaskan Native ☐Other	**Ethnicity:** ☐ Hispanic ☐ Non-Hispanic	

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

INSURANCE INFORMATION – Please mark appropriate category – REQUIRED*

☐ Medicaid: **Select your Centennial Care Plan:** ☐ Blue Cross Blue Shield ☐ Western Sky Community Care ☐ Presbyterian ☐ Other

Centennial Care (Medicaid) Card ID #: _____ Health Insurance Member ID #: _____ Group #: _____

☐ No Insurance ☐ American Indian/Native American/Alaskan Native

☐ Private Insurance – Please list name of insurance: _____

Health Insurance Member ID/ Subscriber #: _____ Group #: _____

MEDICAL SCREENING QUESTIONS FOR CHILDREN AND TEENS – REQUIRED*

For parents/guardians: The following questions will help us determine which vaccines your child may be given today. If you answer "yes" to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.	Yes	No	I don't know
1. Is the child sick today?			
2. Does the child have allergies to medications, food, a vaccine component, or latex?			
3. Has the child has a serious reaction to a vaccine in the past?			
4. Has the child had a health problem with lung, heart, kidney, or metabolic disease (e.g. diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?			
5. If the child to be vaccinated is 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?			
6. If your child is a baby, have you ever been told he or she has had intussusception?			
7. Has the child, sibling, or parent had a seizure; has the child had a brain or other nervous system problems?			
8. Does the child or a family member have cancer, leukemia, HIV/AIDS, or any other immune system problems?			
9. In the past 3 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?			
10. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?			
11. Is the child/teen pregnant or there is a chance she could become pregnant during the next month?			
12. Date of last menstrual period: Date: _____ ☐ N/A			
13. Has the child received vaccinations in the past 4 weeks?			
14. List of current medications: _____			

CONSENT FOR VACCINATION*

I have been given and have read, or have had explained to me, the information in the "Vaccine Information Statement(s)" (VIS) for the disease(s) and the vaccine(s) checked on the other side of this sheet. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccines requested and also understand that I have the alternative to decline the vaccine(s). I ask that the vaccine(s) signed for be given to me or to the person named for whom I am authorized to make this request.

***Signature (Client/Guardian):** _____ ***Date:** _____

***Print Name (Client/Guardian):** _____

***Name of Child (if a minor):** _____ ***Date of Birth:** _____

DIRECT NMSIIS ENTRY OF VACCINES ADMINISTERED IS REQUIRED.

FOR NM DOH OUTREACH ONLY: Data must be entered into TransactRx within 30 days of the date of service.

Patient Name:_____ Date of Birth:_____

FOR CLINIC USE ONLY – All data elements below are required for each vaccine administered*

Vaccine	Vaccine Admin. Date	Lot #	Site/ Route (codes below)	Vaccine Expiration Date	Funding (VFC/State)	VIS Edition Date
DTAP ☐ Daptacel (SP) ☐ Infanrix (GSK)	/ /			/ /		/ /
DTaP/IPV/Hib ☐ Pentacel (SP)	/ /			/ /		/ /
DTaP/HepB/IPV ☐ Pediarix (GSK)	/ /			/ /		/ /
DTaP/IPV ☐ Kinrix (GSK) ☐ Quadracel (SP)	/ /			/ /		/ /
HEP A ☐ Havrix (GSK) ☐ Vaqta (Merck)	/ /			/ /		/ /
HEP B ☐ Engerix B (GSK) ☐ Recombivax (Merck)	/ /			/ /		/ /
Hib ☐ ActHIB (SP) ☐ PedvaxHIB (Merck)	/ /			/ /		/ /
HPV ☐ Gardasil 9 (Merck)	/ /			/ /		/ /
Influenza ☒ Flucelvax (Seqirus) ☐ Fluzone (.25ml/.5ml) (SP) ☐ Flulaval (GSK) ☐ FluMist (AstraZeneca) ☐ Other _____	11/ 02 /2019	261204	LD RD	06 / 26 /2020	VFC	08 / 15 /2019
MCV4 ☐ Menactra (SP) ☐ Menveo (GSK)	/ /			/ /		/ /
Men B ☐ Trumenba (Pfizer) ☐ Bexsero (GSK)						
MMR ☐ MMR II (Merck)	/ /			/ /		/ /
MMRV ☐ ProQuad (Merck)	/ /			/ /		/ /
PCV13 ☐ Prevnar13 (Pfizer)	/ /			/ /		/ /
Polio (IPV) ☐ IPOL (SP)	/ /			/ /		/ /
PPSV23 ☐ Pneumovax 23 (Merck)	/ /			/ /		/ /
Rotavirus ☐ Rotarix (GSK) ☐ RotaTeq (Merck)	/ /			/ /		/ /
Td ☐ Tenivac (SP)	/ /			/ /		/ /
Tdap ☐ Boostrix (GSK)	/ /			/ /		/ /
Varicella ☐ Varivax (Merck)	/ /			/ /		/ /
Other:	/ /			/ /		/ /

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: _____ 17A
(Print Name & Title) (Signature) (Date of Clinic) (Date VIS given) (VFC PIN #)

*Address/location of vaccine given: 1919 Colley Drive Did this vaccination occur at an off-site/outreach clinic? ☐ Yes ☐ No

This form was designed for NM DOH public health offices use only. NM DOH is not responsible for data entry from outside health entities.