# NORTH CAROLINA IMMUNIZATION REGISTRY

*Organization:* [Organization Name]
*Site:* [Site Name]
*Generation Date:* [Date]

## VACCINE ADMINISTRATION RECORD – CHILD

Information collected on this form will be used to document authorization for receipt of vaccine(s). CHART NUMBER:

Patient's Name (Last, First, Middle Initial):

| Gender: ☐ Male ☐ Female ☐ Unknown | Date of Birth (MM/DD/YYYY): | Patient County of Residence: |
|---|---|---|

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Prefer Not to Answer

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ White ☐ Other ☐ Prefer Not to Answer

Mother's Maiden Name (Last, First, Middle Initial):

Eligibility as reported by responsible person (Only check one):
☐ Insured ☐ Not Insured ☐ Underinsured ☐ Medicaid ☐ American Indian/Alaskan Native

| Name of Responsible Person for Patient (Last, First, Middle Initial): | Relationship to Patient (e.g., Self, Mother/Father, Grandparent, etc.): |
|---|---|
| Address: | P.O. Box |

| City: | County: | State: | Zip: |
|---|---|---|---|

| Email Address: | Home Telephone Number: | Work Telephone Number: | Extension: |
|---|---|---|---|

Would you like a reminder/recall sent to you? ☐ Yes ☐ No

I am the person receiving the vaccine/I am the parent/I am authorized by the parent, guardian, or person standing in loco parentis of the above-named patient to obtain needed vaccines for the patient.

I have received the "Vaccine Information Statements" (VIS) about the disease(s) and vaccine(s). I have had a chance to review the VIS(s) and to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and request the vaccine(s) indicated below to be given to me or the person named above for whom I am authorized to make this request.

| **SIGNATURE** (Person to receive vaccine or person authorized to sign on the patient's behalf): | Date Signed: |
|---|---|
| **X** | |

**FOR OFFICE USE:**

| Immunization | Trade Name | Lot | Dose Amount | Body Site | | | | Route | Date of Admin | VIS Pub. Date | Notes |
|---|---|---|---|---|---|---|---|---|---|---|---|
| COVID-19 | | | | RV | LV | RD | LD | IM | | | |
| Flu | | | | RV | LV | RD | LD | IM | | | |
| DTaP/Tdap | | | | RV | LV | RD | LD | IM | | | |
| HepB | | | | RV | LV | RD | LD | IM | | | |
| Hib | | | | RV | LV | RD | LD | IM | | | |
| MMR | | | | RV | LV | RD | LD | IM / SC | | | |
| Pneumococcal | | | | RV | LV | RD | LD | IM / SC | | | |
| Polio | | | | RV | LV | RD | LD | IM | | | |
| Varicella | | | | RV | LV | RD | LD | SC | | | |
| Rotavirus | | | | RV | LV | RD | LD | O | | | |
| HepA | | | | RV | LV | RD | LD | IM | | | |
| Other | | | | | | | | | | | |

*RV = Right Vastus Lateralis LV = Left Vastus Lateralis RD = Right Deltoid LD = Left Deltoid

*Subcutaneous (SC) injections are administered in the muscle "area".

Ordering Authority (Please Print):

Administered By (Please Print):

**SIGNATURE AND TITLE** (Person administering vaccine):
**X**