NEW MEXICO DEPARTMENT OF HEALTH

NM VFC Vaccine Administration Form – Part B

rev. 7/23/10

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

New Mexico VFC Program

Person receiving vaccine: **Please print in all capitals**

* Last Name: _____ * First Name: _____ MI: _____

* Date of Birth: ____/___/_____ (mm dd yyyy)

* Mother's Maiden Name: _____

* Mother's First Name: _____

Sex: ☐ Male ☐ Female

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Race: ☐ African American ☐ American Indian ☐ Asian ☐ Other ☐ White

*Mailing Address _____ *City _____ *State _____ *Zip code _____

_____

*Responsible Person: _____ (Last Name) _____ (First Name) *Relationship: _____

INSURANCE STATUS

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

☐ No health insurance
☐ American Indian
☐ Medicaid/Salud – **place check mark next to plan:**
__Blue Cross Medicaid/Salud ___Molina Medicaid/Salud
__Lovelace Medicaid/Salud ___Presbyterian Medicaid/Salud
__Medicaid FFS ___United Healthcare Medicaid/Salud

Medicaid #_____

Private/Commercial insurance:
☐ Blue Cross Blue Shield
☐ Lovelace
☐ Presbyterian
☐ United Healthcare
☐ Other: _____
(indicate company name)

Policy # _____

FOR CLINIC USE ONLY

*** ENTER THE APPROPRIATE TRADE NAME, LOT #, DATE of VIS, and SITE/ROUTE FOR EACH VACCINE GIVEN**

Vaccine	Lot #	Date of VIS	Site/ Route (Codes below)	Vaccine	Lot #	Date of VIS	Site/ Route (Codes below)
DT				**HPV** ☐ Cervarix ☐ Gardasil			
DTAP ☐ Daptacel ☐ Infanrix				**Influenza**			
DTaP-HepB-IPV (Pediarix)				**MCV** ☐ Menactra ☐ Menveo			
DTaP–IPV–Hib (Pentacel)				**MMR**			
DTaP–IPV (Kinrix)				**MMRV** (ProQuad)			
HBIG				**PCV** (Prevnar)			
HEP A ☐ Havrix ☐ Vaqta				**Polio IPV**			
HEP B ☐ Engerix ☐ Recombivax				**PPSV (Pneumovax)**			
Hep A–Hep B (Twinrix)				**Rotavirus** ☐ Rotarix ☐ RotaTeq			
Hep B–Hib (Comvax)				**Td** (Decavac)			
Hib (ActHib)				**Tdap** ☐ Boostrix ☐ Adacel			
Hib (Hiberix)				**Varicella** (Varivax)			
Hib (PedvaxHib)							

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**) * _____ (**SIGNATURE**) * _____ (**DATE OF SERVICE**) * VFC Pin #: _____

Direct NMSIIS entry of vaccines administered is required for VFC participation.