Brown County Public Health
1117 Center St · PO Box 543 · New Ulm, MN 56073
Phone (507) 233-6820 · Fax (507) 233-6819

VACCINE ADMINISTRATION RECORD

Please complete and sign this form. If you do not fill it out completely, you may be denied immunization services. The form may be kept in your child's medical file. This information is private and will not be shared with anyone except healthcare agencies, childcare facilities, and schools to help them provide immunization services, make sure immunization requirements have been met, and prevent disease by monitoring immunization needs. These agencies may include the Minnesota Department of Health (MDH); Minnesota Immunization Information Connection (MIIC); licensed healthcare professionals such as doctors and nurses; licensed healthcare facilities such as hospitals and clinics; health insurers; Head Start programs; county public health agencies; and community action agencies. The information contained within this record is being maintained to monitor immunization needs in order to prevent disease and to assess and/or provide immunization services or to facilitate future enrollment in a child care facility, school, or college.

PLEASE COMPLETE SHADED AREA

Information about person to receive vaccine

PLEASE PRINT

Last Name	First Name	M I	Birthdate	Age	Sex M F

Address	City	State	Zip	County

Phone		Mother's First Name

School	Grade	Mother's **Maiden** Name

Please check appropriate box(es) to indicate which vaccines you want your child to receive

☐ Hep A ☐ HPV ☐ Meningococcal ☐ Tdap ☐ Varicella

I have read or have had explained to me the fact sheet(s) known as "Vaccine Information Statements (VIS)", about the vaccine(s) and disease(s) indicated above. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the indicated vaccine(s) and ask that the vaccine(s) be given to me or to the person named above. If the person named above is a minor child, I attest that I am the child's parent, authorized representative, or legal guardian and may provide consent for the immunization(s).

Signature of person to receive vaccine(s) or, in the case of a minor child, the parent, authorized representative, or legal guardian

X_____ Date:_____

FOR CLINIC/OFFICE USE ONLY

Vaccine type	Hep A	HPV	Meningococcal	Tdap	Varicella
Manufacturer					
Lot number					
Site of injection/route	IM-LD IM-RD	IM-LD IM-RD	IM-LD IM-RD	IM-LD IM-RD	IM-LD IM-RD
Given by (initials*)					

**Signature(s) and title of person(s) administering vaccine*	*Initial*	*Date Given/VIS Given*	*Circle Vaccine Given*
			Hep A 10/25/2011
			HPV 05/17/2013
			Meningococcal 10/14/2011
			Tdap 05/09/2013
			Varicella 03/13/2008