

Vaccine Documentation Form

(800) 252-9152

| Date    | Vaccine                                     | Mfg. | Lot No. | Site Given | Given by | VIS Date |
|---------|---|------|---------|------------|----------|----------|
|         | Hepatitis B                                 |      |         |            |          |          |
|         | Hepatitis B                                 |      |         |            |          |          |
|         | Hepatitis B                                 |      |         |            |          |          |
|         | DTaP/DT/DTP/Td/Tdap                         |      |         |            |          |          |
|         | DTaP/DT/DTP/Td/Tdap                         |      |         |            |          |          |
|         | DTaP/DT/DTP/Td/Tdap                         |      |         |            |          |          |
|         | DTaP/DT/DTP/Td/Tdap                         |      |         |            |          |          |
|         | DTaP/DT/DTP/Td/Tdap                         |      |         |            |          |          |
|         | DTaP/DT/DTP/Td/Tdap                         |      |         |            |          |          |
|         | Hib   |      |         |            |          |          |
|         | Hib   |      |         |            |          |          |
|         | Hib   |      |         |            |          |          |
|         | Hib   |      |         |            |          |          |
|         | Pneumococcal Conjugate                      |      |         |            |          |          |
|         | Pneumococcal Conjugate                      |      |         |            |          |          |
|         | Pneumococcal Conjugate                      |      |         |            |          |          |
|         | Pneumococcal Conjugate                      |      |         |            |          |          |
|         | IPV/OPV                                     |      |         |            |          |          |
|         | IPV/OPV                                     |      |         |            |          |          |
|         | IPV/OPV                                     |      |         |            |          |          |
|         | IPV/OPV                                     |      |         |            |          |          |
|         | Rotavirus                                   |      |         |            |          |          |
|         | Rotavirus                                   |      |         |            |          |          |
|         | Rotavirus                                   |      |         |            |          |          |
|         | MMR   |      |         |            |          |          |
|         | MMR   |      |         |            |          |          |
|         | Measles (Sarampión)                         |      |         |            |          |          |
|         | Varicella (Chickenpox)                      |      |         |            |          |          |
|         | Varicella (Chickenpox)                      |      |         |            |          |          |
|         | Varicella History/Date of Varicella Disease |      |         |            |          |          |
|         | MCV4  |      |         |            |          |          |
|         | MPSV4                                       |      |         |            |          |          |
|         | Hepatitis A                                 |      |         |            |          |          |
|         | Hepatitis A                                 |      |         |            |          |          |
|         | HPV   |      |         |            |          |          |
|         | HPV   |      |         |            |          |          |
|         | HPV   |      |         |            |          |          |
|         | Pneumococcal Polysaccharide                 |      |         |            |          |          |
|         | Influenza                                   |      |         |            |          |          |
|         | Influenza                                   |      |         |            |          |          |
|         |   |      |         |            |          |          |
|         |   |      |         |            |          |          |
| TB Test | Date Read                                   | mm   | TB Test | Date Read  | mm       |          |
| TB Test | Date Read                                   | mm   | TB Test | Date Read  | mm       |          |

Last/Apellido \_\_\_\_\_ First/Nombre \_\_\_\_\_ Middle/Segundo nombre \_\_\_\_\_  
 Birth date/Fecha de nacimiento \_\_\_\_\_ Sex/Sexo \_\_\_\_\_ Race/Raza \_\_\_\_\_  
 Address/Dirección \_\_\_\_\_ Telephone Number/Número de teléfono \_\_\_\_\_  
 City/Ciudad \_\_\_\_\_ State/Estado \_\_\_\_\_ Zip/Código postal \_\_\_\_\_ County/Condado \_\_\_\_\_  
 Social Security Number/Número de Seguro Social \_\_\_\_\_ Medicaid Number/Número de Medicaid \_\_\_\_\_  
 WIC Number/Número de WIC \_\_\_\_\_  
 Parent's Name/Nombre del padre o de la madre \_\_\_\_\_  
 Mother's Maiden Name/Apellido de soltera de la madre \_\_\_\_\_



Stock No. C-100  
Revised 09/2006



I received or was offered a copy of the Vaccine Information Statement (VIS) for each vaccine. I know the risks of the disease each vaccine prevents. I know the benefits and risks of each vaccine. I have had a chance to ask questions about the disease, the vaccines, and how the vaccines are given. I know that the person receiving the vaccine will have the vaccine put into his/her body to prevent an infectious disease. I am an adult who can legally consent for the person named below to get the vaccine. I freely and voluntarily give my signed permission for the vaccines.

Recibí o se me ofreció una hoja con información sobre cada vacuna (VIS). Conozco los riesgos de las enfermedades que cada vacuna previene. Conozco los beneficios y riesgos que estas vacunas tienen. He tenido la oportunidad de hacer preguntas sobre las enfermedades, las vacunas y cómo son administradas las vacunas. Sé que la persona recibiendo la vacuna la tendrá en su cuerpo para prevenir una enfermedad contagiosa. Soy adulto y puedo dar permiso legalmente para que le den la vacuna a la persona nombrada abajo. Por mi propia voluntad firmo y doy permiso para que le den esta vacuna.

**Privacy Notification:** With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See <http://www.dshs.state.tx.us> for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

**Notificación Sobre Privacidad:** Tan solo por unas cuantas excepciones, usted tiene el derecho de solicitar y de ser informado sobre la información que el Estado de Texas reúne sobre usted. A usted se le debe conceder el derecho de recibir y revisar la información al requerirla. Usted también tiene el derecho de pedir que la agencia estatal corrija cualquier información que se ha determinado sea incorrecta. Diríjase a <http://www.dshs.state.tx.us> para más información sobre la Notificación sobre privacidad. (Referencia: Government Code, Sección 552.021, 552.023, 559.003 y 559.004)

**Privacy Notice:** I acknowledge that I have received a copy of my immunization provider's HIPAA Privacy Notice.

**Aviso sobre derechos de la vida privada:** Yo admito haber recibido una copia del aviso sobre derechos de la vida privada.

Yes, HIPAA received  No HIPAA received

Si. Recibí HIPAA  No Recibí HIPAA

| Hepatitis B                         | DTaP/DT/DTp/Td/Tdap      | Hib                      | Pneumococcal Conjugate   | IPV/OPV                  | Rotavirus                | MMR                      | Measles (Sarampión)      | Varicella (Chickenpox)   | MCV4                     | MPSV4                    | Hepatitis A              | HPV                      | Pneumococcal Polysaccharide | Influenza                | DATE | Signature/Relation/Address/Telephone<br>Firma/Relación/Dirección/Teléfono |
|-------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|-----------------------------|--------------------------|------|---|
| <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>    | <input type="checkbox"/> |      |   |
| Witness Signature/Firma del Testigo |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                             |                          |      |   |
| Witness Signature/Firma del Testigo |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                             |                          |      |   |
| Witness Signature/Firma del Testigo |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                             |                          |      |   |
| Witness Signature/Firma del Testigo |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                             |                          |      |   |
| Witness Signature/Firma del Testigo |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                             |                          |      |   |
| Witness Signature/Firma del Testigo |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                             |                          |      |   |
| Witness Signature/Firma del Testigo |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                             |                          |      |   |
| Witness Signature/Firma del Testigo |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                             |                          |      |   |
| Witness Signature/Firma del Testigo |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                             |                          |      |   |

Check vaccines to be given then enter date, sign, and complete the section below.

Señale las vacunas que se van a dar, escriba la fecha, firme y llene la parte de abajo.

