

**Idaho's Immunization Reminder Information System**

*Organization: IR Physicians Site: IR Physicians*

**Vaccine Administration Record**

**PATIENT ID**

Patient's Name (Last Suffix, First Middle)		Current Age	Country of Birth
Address			P.O. Box
City		State	Zip Code
Date of Birth (mm/dd/yyyy)	Gender	Ethnicity (Check One) <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
Race (Check One) <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Other	Mother's (if married, patient's) Maiden Name (Last, First, Middle)		
Name of Primary Care Provider (First Last)		School or Day Care (if applicable)	

Name of Parent or Guardian Responsible for Patient (Last, First)			Relationship to Patient	
Address			P.O. Box	
City	County	State	Zip Code	
Email address (if applicable)	Home Telephone Number	Work Telephone Number (      )	Extension	

Name of Parent or Guardian Responsible for Patient (Last, First)			Relationship to Patient	
Address			P.O. Box	
City	County	State	Zip Code	
Email address (if applicable)	Home Telephone Number	Work Telephone Number (      )	Extension	

*Data gathered on this form will be entered into Idaho's Immunization Reminder Information System (IRIS). If you wish to Opt-Out of IRIS, please contact the Immunization Program at iip@dhw.idaho.gov or 208-334-5931 for instructions.*

Is reminder/recall contact allowed?

<b>VFC Eligibility Status</b> (Check all that apply) <b>This section must be completed.</b>	<input type="checkbox"/> Ineligible	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Uninsured
	<input type="checkbox"/> American Indian/Alaskan Native	<input type="checkbox"/> Underinsured FQHC/RHC	<input type="checkbox"/> Underinsured

I have been given a copy and have read, or have had explained to me, information about the disease(s) and vaccine(s) to be received. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine(s) be given to me or to the person named above for whom I am authorized to make this request.

<b>SIGNATURE</b> - Person to receive vaccine or person authorized to sign on the patient's behalf	Date Signed
<b>X</b>	

**FOR OFFICE USE**

Vaccine	VIS Date	Body Route	Body Site*
DTP/aP	05/17/2007	IM	RV LV RD LD
HepB	07/18/2007	IM	RV LV RD LD
Hib	12/16/1998	IM	RV LV RD LD
MMR	03/13/2008	SC	RV LV RD LD
Mening	01/28/2008		RV LV RD LD
Pneumococcal	04/16/2010	IM	RV LV RD LD
Polio	01/01/2000		RV LV RD LD
Varicella	03/13/2008	SC	RV LV RD LD
Other			

\*RV = Right Vastus Lateralis LV = Left Vastus Lateralis RD = Right Deltoid LD = Left Deltoid Subcutaneous injections are administered in the muscle "area".

SIGNATURE AND TITLE - Person Administering Vaccine	Date Vaccine Administered
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