YOU MUST MARK WHICH SHOT YOUR CHILD NEEDS

VACCINE ADMINISTRATION RECORD

BRING SHOT RECORD TO CLINIC WITH YOU

I have been given a copy and have read or have had explained to me the Information in the "Vaccine Information Statement(s)" for the disease(s) and vaccine(s) checked below. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine(s) checked below be given to me or to the person named below for whom I am authorized to make this request.

❑ Tdap ❑ MCV ❑ HAV ❑ RV ❑ Flu ❑ DTaP ❑ HBV ❑ Hib

❑ IPV ❑ MMR ❑ PCV, ❑ Td ❑ VAR ❑ OTHER _____

Information about Person to receive vaccine (Please Print)					
Name: Last	First	M.I.	Birthdate	Age	
Address: Street	City	County	State	Zip	
Race/Ethnicity ❑ Caucasian ❑ African American ❑ Asian ❑ American Indian ❑ Hispanic ❑ Other _____					
❑ Medicaid ❑ Uninsured ❑ *Underinsured Physician _____					
Signature of person to receive vaccine or person authorized to make the request (PARENT)			Date		

* Underinsured = Have insurance that does not cover vaccines.

FH-24 Rev. 7/06 (24324)
(Previous version 4/01 should be used first)

MOTHER'S MAIDEN NAME: _____ PHONE NUMBER: _____