NM VFC School Vaccine Administration Form

Form must be filled in completely.

New Mexico Vaccines for Children

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

Last Name: ______________________________ First Name: __________________________________ MI: ____

Date of Birth: ____/___/______ Child's Age: ________ Mother's Maiden Name: ______________________________
mm dd yyyy

Mother's First Name: ________________________________

Sex: ☐ Male ☐ Female **Ethnicity**: ☐ Hispanic ☐ Non-Hispanic **Race**: ☐ American Indian ☐ White ☐ Asian ☐ African-American ☐ Other

Mailing Address: __________________________ City: _____________________ State: ______ Zip: ________

Responsible Person: ____ Relationship: ________________________
(Last Name) (First Name)

INSURANCE STATUS

For children 0–18 years of age, please mark appropriate category (Must Be Completed):

☐ No health insurance
☐ American Indian
☐ Medicaid/Salud – **place check mark next to plan**:

__Blue Salud __Molina Salud
__Lovelace Salud __Presbyterian Salud
__Medicaid __Other ________________

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

Medicaid Salud # ______________________________ Policy# ______________________________

I have been given 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 understand the benefits and risks of the vaccines requested and also understand that I have the alternative to decline vaccines. I ask that the vaccines signed for below be given to the person named for whom I am authorized to make this request. I understand that some immunizations are given in a series over a period of time and that by signing this form I agree that the immunizations marked below will be given, including those needed to complete a series. I agree to report any problems that arise, and direct any questions I may have to the School Nurse. I also understand that I may request from the School Nurse procedures on how to lawfully discontinue a vaccine series once begun. I agree to allow information on immunizations given to the named person to be released to other medical care providers to avoid unnecessary vaccination or to ascertain immunization status. I also understand that my medical care provider may release this information to the state immunization registry (NMSIIS) unless I sign a document indicating my refusal.

Parent/guardian signature: ____ Date: ____________________

BELOW: FOR SCHOOL NURSE USE ONLY

Name of School: ______________________________ **VFC Pin #:** ________________

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

Vaccine		Manufacturer	Lot #:
☐DTaP	☐MMR	☐GSK	
☐DTaP.IPV	☐PCV	☐MedImmune	Injection Site:
☐Hep A	☐Polio	☐Merck	
☐Hep B	☐Rotavirus	☐Novartis	Date: ________
☐Hib	☐Tdap	☐Pfizer	
☐HPV	☐Varicella	☐Sanofi Pasteur	VIS Date: ________
☑Influenza	☐Other:		
☐MCV4		Vaccinator:	

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☐Hep A	☐Polio	☐Merck	
☐Hep B	☐Rotavirus	☐Novartis	Date: ________
☐Hib	☐Tdap	☐Pfizer	
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☐Influenza	☐Other:		
☐MCV4		Vaccinator:	

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)