Immunization Information

Vaccine Information Statements (VIS) are given to the patient/guardian prior to administering immunizations. Give patient/guardian opportunity to ask questions.

Vaccine Circle Type Given	Dose	Date VIS/Vaccine Given	Site	Route Circle, if applicable	Vaccine Manufacturer	Vaccine Lot or Control Number	VIS Date	Provider ID * See ID Below	Eligibility Status **See Table Below
HBIG				IM					
Hep B	1			IM					
Hep B	2			IM					
Hep B	3			IM					
IPV	1			IM or SC					
IPV	2			IM or SC					
IPV	3			IM or SC					
IPV	4			IM or SC					
DTaP/DT	1			IM					
DTaP/DT	2			IM					
DTaP/DT	3			IM					
DTaP/DT	4			IM					
DTaP/DT	5			IM					
Hib	1			IM					
Hib	2			IM					
Hib	3			IM					
Hib	4			IM					
PCV	1			IM					
PCV	2			IM					
PCV	3			IM					
PCV	4			IM					
Rota	1			PO					
Rota	2			PO					
Rota	3			PO					
Hep A	1			IM					
Hep A	2			IM					
MMR	1			SC					
MMR	2			SC					
VAR	1			SC					
VAR	2			SC					

♦A reliable history of Chickenpox is defined as: 1). Physician interpretation of parent/guardian description of Chickenpox: 2). Physician diagnosis of Chickenpox; or 3). Serologic proof of immunity.

♦Varicella Disease: Yes ☐ Date Box Checked ____/____/____ Check box if child has a reliable history of Chickenpox♦

HPV	1			IM					
HPV	2			IM					
HPV	3			IM					
MCV4	1			IM					
MCV4	2			IM					

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MEN B	1			IM					
MEN B	2			IM					
MEN B	3			IM					
Tdap				IM					
Td				IM					
Td				IM					
Td				IM					
PPSV23				IM or SC					

OTHER IMMUNIZATIONS:

ALLERGIES/COMMENTS:

PRACTICE NAME & ADDRESS:

***Provider ID:** Each person administering vaccines to this patient should sign below, and place his/her initials next to the signature. When immunizations are administered, the provider only needs to record his/her initials in the Provider ID column.

Patient's Name

Patient's Date of Birth

Patient's ID Number

Eligibility Status Table:

VFC	A- Medicaid- enrolled
VFC	B- No Health Insurance
VFC	C- American Indian/Alaskan Native
VFC	D- [1]Underinsured (served in FQHC/RHC or Dep. Facility)
Non-VFC	E- Insured (private pay/health ins. covers vaccines)
Non-VFC	F- [2]SC State Underinsured(Non- FQHC's and RHC's)
Non-VFC	G- [3]SC State Insured (Insured Hardship and Vaccine Caps)

Eligibility Explained: ***The Meningococcal B Vaccine is excluded from the SC State Vaccine Program.***

[1]**Underinsured-** *includes children with health insurance that does not include vaccines or only covers specific vaccine types. Children are only eligible for vaccines that are not covered by insurance.*

[2]**SC State Underinsured-***These children are underinsured but are not eligible to receive federal vaccine through the VFC program because the provider or facility is not an **FQHC/RHC or a deputized provider**. However, these children may be served with state vaccine program vaccine to cover these non-VFC eligible children.*

[3] **SC State Insured** - *Insured Hardship and Vaccine Caps: These children are considered insured and are not eligible for vaccines through the VFC program. However, these children may be served state vaccine program vaccine to cover these non-VFC eligible children. Insured Hardship is defined as "Health Insurance deductible is greater than $500.00 per child or $1000.00 per family (Eligible for state vaccine only if the deductible has not been met and the family cannot afford to pay for vaccine)." Vaccine Caps is defined as "Insured but coverage capped at certain amount and cap has been exceeded."*

Vaccine Abbreviations

DT	Pediatric Diphtheria & Tetanus Vaccine	MCV4	Meningococcal Conjugate Vaccine (quadrivalent)
DTaP	Pediatric Diphtheria, Tetanus & Acellular Pertussis Vaccine	MEN B	Meningococcal Group B Vaccine
HAV	Hepatitis A Vaccine	MMR	Measles, Mumps & Rubella
HBV	Hepatitis B Vaccine	MMRV	Measles, Mumps, Rubella & Varicella Vaccine
Hib	*Haemophilus influenzae* type b Vaccine	PCV (7 or 13)	Pneumococcal Conjugate Vaccine (7-valent or 13-valent)
HPV	Human Papillomavirus Vaccine	PPSV23	Pneumococcal Polysaccharide Vaccine (23-valent)
IIV3	Inactivated Influenza Vaccine, Trivalent	Rota	Rotavirus Vaccine (RV1=Rotarix, RV5=Rotateq)
IIV4	Inactivated Influenza Vaccine, Quadrivalent	Td	Adult Tetanus & Diphtheria Vaccine
IPV	Inactivated Polio Vaccine	Tdap	Adolescent /Adult Tetanus, Diphtheria & Acellular Pertussis Vaccine
LAIV4	Live, Attenuated Influenza Vaccine, Quadrivalent (FluMist)	VAR	Varicella Vaccine

Department of Health and Environmental Control
IMMUNIZATION INFORMATION (DHEC 1103V)

Instructions For Completing

PURPOSE

To provide immunization providers with a form to document immunization services in accordance with federal law, and to retain all immunization data in one location in the patient's medical record. Immunization providers are required to document the: name of each vaccine administered, injection site and route, date the VIS was given, date each vaccine was administered (month, day, year), name of each vaccine's manufacturer, lot number of each vaccine, signature and title of the person who administered each vaccine (the signature may be electronic and/or code identified), address of the clinic administering vaccinations to the patient, patient's name, patient's date of birth, edition date (month, day, year) printed on each Vaccine Information Statement (VIS), and federal Vaccines for Children (VFC) Program eligibility.

INSTRUCTIONS

1. For each vaccine administered, record the date given, injection site, vaccine manufacturer, vaccine lot/control number, and VIS date.
2. Where applicable, circle the appropriate administration route abbreviation: IM for Intramuscular, SC for Subcutaneous, PO for Oral and IN for Intranasal.
3. For DTaP/DT, circle the vaccine given.
4. The person administering the vaccine(s) should sign his/her name once in the Provider ID space provided at the bottom of the form, followed by his/her initials. Then, for this immunization visit and future immunization visits, the person administering the vaccine(s) only needs to record his/her initials in the Provider ID column.
5. From the Eligibility Status Table provided at the bottom of the form, select the appropriate eligibility status and record the associated letter in the Eligibility Status column for each vaccine administered. (e.g., patient may be VFC-eligible for certain vaccine(s); not eligible for all others)
6. Varicella Disease: If child has a reliable history of Chickenpox, check the "yes" block and record the date the block was checked.
7. Allergies/Comments: Record any allergies the patient has, as well as any comments deemed necessary.
8. Record the name and address of the medical practice.
9. Document patient demographic information: Name, Date-of-Birth, and Identification (ID) Number assigned by the medical practice.
10. Retain this form in the patient medical record, preferably on top. Review the immunization history of the patient at each visit, and, if applicable, administer needed vaccinations.

Office Mechanics and Filing:

1. The completed Immunization Information form is kept on file by the provider.