

Patient name: _____ Date of birth: _____
 (mo.) (day) (yr.)

Screening Questionnaire for Child and Teen Immunization

For parents/guardians: The following questions will help us determine which vaccines your child may be given today. If you answer "yes" to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1. Is the child sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the child have allergies to medications, food, a vaccine component, or latex?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the child had a serious reaction to a vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the child had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. If the child to be vaccinated is between the ages of 2 and 4 years, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Does the child have cancer, leukemia, AIDS, or any other immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. In the past 3 months, has the child taken cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Has the child received vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Form completed by: _____ Date: _____

Form reviewed by: _____ Date: _____

Did you bring your child's immunization record card with you? yes no

It is important to have a personal record of your child's vaccinations. If you don't have a personal record, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep this record in a safe place and bring it with you every time you seek medical care for your child. Your child will need this important document for the rest of his or her life to enter day care or school, for employment, or for international travel.

Information for Health Professionals about the Screening Questionnaire for Child & Teen Immunization

Are you interested in knowing why we included a certain question on the Screening Questionnaire? If so, read the information below. If you want to find out even more, consult the references listed at the bottom of this page.

1. Is the child sick today? [all vaccines]

There is no evidence that acute illness reduces vaccine efficacy or increases vaccine adverse events (1, 2). However, as a precaution with moderate or severe acute illness, all vaccines should be delayed until the illness has improved. Mild illnesses (such as otitis media, upper respiratory infections, and diarrhea) are NOT contraindications to vaccination. Do not withhold vaccination if a person is taking antibiotics.

2. Does the child have allergies to medications, food, a vaccine component, or latex? [all vaccines]

History of anaphylactic reaction such as hives (urticaria), wheezing or difficulty breathing, or circulatory collapse or shock (not fainting) to a vaccine component or latex is a contraindication to some vaccines. For example, if a person experiences anaphylaxis after eating eggs, do not administer influenza vaccine, or if a person has anaphylaxis after eating gelatin, do not administer measles-mumps-rubella (MMR), MMR+varicella (MMRV), or varicella (VAR) vaccine. A local reaction is not a contraindication. For a table of vaccines supplied in vials or syringes that contain latex, go to www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/latex-table.pdf. For an extensive table of vaccine components, see reference 3.

3. Has the child had a serious reaction to a vaccine in the past? [all vaccines]

History of anaphylactic reaction (see question 2) to a previous dose of vaccine or vaccine component is a contraindication for subsequent doses (1). History of encephalopathy within 7 days following DTP/DTaP is a contraindication for further doses of pertussis-containing vaccine. Precautions to DTaP (not Tdap) include the following: (a) seizure within 3 days of a dose, (b) pale or limp episode or collapse within 48 hours of a dose, (c) continuous crying for 3 or more hours within 48 hours of a dose, and (d) fever of 105°F (40°C) within 48 hours of a previous dose. There are other adverse events that might have occurred following vaccination that constitute contraindications or precautions to future doses. Under normal circumstances, vaccines are deferred when a precaution is present. However, situations may arise when the benefit outweighs the risk (e.g., during a community pertussis outbreak).

4. Has the child had a health problem with lung, heart, kidney, or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy? [IAIV]

Children with any of the health conditions listed above should not be given the intranasal, live attenuated influenza vaccine (IAIV). These children should be vaccinated with the injectable influenza vaccine.

5. If the child to be vaccinated is between the ages of 2 and 4 years, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months? [IAIV]

Children who have had a wheezing episode within the past 12 months should not be given the live attenuated influenza vaccine. Instead, these children should be given the inactivated influenza vaccine.

6. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problem? [DTaP, Td, Tdap, TIV, IAIV, MMRV]

DTaP and Tdap are contraindicated in children who have a history of encephalopathy within 7 days following DTP/DTaP. An unstable progressive neurologic problem is a precaution to the use of DTaP and Tdap, and a progressive neurologic disorder in a teen is a precaution to the use of Td. For children with stable neurologic disorders (including seizures) unrelated to vaccination, or for children with a family history of seizures, vaccinate as usual (exception: children with a personal or family [i.e., parent or sibling] history of seizures generally should not be vaccinated with MMRV; they should receive separate MMR and VAR vaccines). A history of Guillain-Barré syndrome (GBS) is a consideration with the following: 1) Td/Tdap: if GBS has occurred within 6 weeks of a tetanus-containing vaccine and decision is made to continue vaccination, give age-appropriate Tdap instead of Td if no history of prior Tdap; 2) Influenza vaccine (TIV or IAIV): if GBS has occurred within 6 weeks of a prior influenza vaccination, vaccinate with TIV if at high risk for severe influenza complications.

7. Does the child have cancer, leukemia, AIDS, or any other immune system problem? [IAIV, MMR, MMRV, RV, VAR]

Live-virus vaccines (e.g., MMR, MMRV, varicella; rotavirus, and the intranasal live, attenuated influenza vaccine [IAIV]) are usually contraindicated in immunocompromised children. However, there are exceptions. For example, MMR is recommended for asymptomatic HIV-infected children who do not have evidence of severe immunosuppression. Likewise, varicella vaccine should be considered for HIV-infected children with age-specific CD4+ T-lymphocyte percentage at 15% or greater and may be considered for children age 8 years and older with CD4+ T-lymphocyte counts of greater than or equal to 200 cells/ μ L. Immunosuppressed children should not receive IAIV. Infants who have been diagnosed with severe combined immunodeficiency (SCID) should not be given a live virus vaccine, including rotavirus (RV) vaccine. For details, consult the ACIP recommendations (4, 5, 6).

8. In the past 3 months, has the child taken cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments? [IAIV, MMR, MMRV, VAR]

Live virus vaccines (e.g., MMR, MMRV, varicella, IAIV) should be postponed until after chemotherapy or long-term high-dose steroid therapy has ended. For details and length of time to postpone, consult the ACIP statement (1). To find specific vaccination schedules for stem cell transplant (bone marrow transplant) patients, see reference 7. IAIV can be given only to healthy non-pregnant individuals age 2–49 years.

9. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? [IAIV, MMR, MMRV, VAR]

Certain live virus vaccines (e.g., IAIV, MMR, MMRV, varicella) may need to be deferred, depending on several variables. Consult the most current ACIP recommendations or the current Red Book for the most current information on intervals between antiviral drugs, immune globulin or blood product administration and live virus vaccines (1, 2).

10. Is the child/teen pregnant or is there a chance she could become pregnant during the next month? [IAIV, MMR, MMRV, VAR]

Live virus vaccines (e.g., MMR, MMRV, varicella, IAIV) are contraindicated one month before and during pregnancy because of the theoretical risk of virus transmission to the fetus (1, 6). Sexually active young women who receive a live virus vaccine should be instructed to practice careful contraception for one month following receipt of the vaccine (5, 8). On theoretical grounds, inactivated poliovirus vaccine should not be given during pregnancy; however, it may be given if risk of disease is imminent (e.g., travel to endemic areas) and immediate protection is needed. Use of Td or Tdap is not contraindicated in pregnancy. At the provider's discretion, either vaccine may be administered during the 2nd or 3rd trimester (9).

11. Has the child received vaccinations in the past 4 weeks? [IAIV, MMR, MMRV, VAR, yellow fever]

If the child was given either live, attenuated influenza vaccine (IAIV) or an injectable live virus vaccine (e.g., MMR, MMRV, varicella, yellow fever) in the past 4 weeks, they should wait 28 days before receiving another vaccination of this type. Inactivated vaccines may be given at the same time or at any spacing interval.

References

1. CDC. General recommendations on immunization at www.cdc.gov/vaccines/imzinfos/draft.htm.
2. AAP. Red Book: Report of the Committee on Infectious Diseases at www.aapredbook.org.
3. Table of Vaccine Components: www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/exceptions-table-7.pdf.
4. CDC. Measles, mumps, and rubella—vaccine use and strategies for elimination of measles, rubella, and congenital rubella syndrome and control of mumps. *MMWR* 1998; 47 (RR-5).
5. CDC. Prevention of varicella: Recommendations of the Advisory Committee on Immunization Practices. *MMWR* 2007; 56 (RR-4).
6. CDC. Prevention and Control of Influenza—Recommendations of ACIP at www.cdc.gov/flu/immunization/vaccinat.cfm.
7. CDC. Excerpt from Guidelines for preventing opportunistic infections among hematopoietic stem cell transplant recipients. *MMWR* 2000; 49 (RR-10); www.cdc.gov/vaccines/pubs/downloads/flu_rec-rec.pdf.
8. CDC. Notice to readers: Revised ACIP recommendation for avoiding pregnancy after receiving a rubella-containing vaccine. *MMWR* 2001; 50 (49).
9. CDC. Prevention of pertussis, tetanus, and diphtheria among pregnant and postpartum women and their infants: Recommendations of the ACIP. *MMWR* 2001; 57 (RR-4).

Patient name: _____

Date of birth: _____
(mo.) (day) (yr.)

Screening Questionnaire for Adult Immunization

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1. Are you sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have allergies to medications, food, a vaccine component, or latex?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had a serious reaction after receiving a vaccination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have cancer, leukemia, AIDS, or any other immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you had a seizure or a brain or other nervous system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you received any vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Form completed by: _____ Date: _____

Form reviewed by: _____ Date: _____

Did you bring your immunization record card with you? yes no

It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.

Information for Health Professionals about the Screening Questionnaire for Adults

Are you interested in knowing why we included a certain question on the Screening Questionnaire? If so, read the information below. If you want to find out even more, consult the references listed at the bottom of this page.

1. Are you sick today? *[all vaccines]*

There is no evidence that acute illness reduces vaccine efficacy or increases vaccine adverse events (1). However, as a precaution with moderate or severe acute illness, all vaccines should be delayed until the illness has improved. Mild illnesses (such as upper respiratory infections or diarrhea) are NOT contraindications to vaccination. Do not withhold vaccination if a person is taking antibiotics.

2. Do you have allergies to medications, food, a vaccine component, or latex? *[all vaccines]*

History of anaphylactic reaction such as hives (urticaria), wheezing or difficulty breathing, or circulatory collapse or shock (not fainting) to a vaccine, component or latex is a contraindication to some vaccines. For example, if a person experiences anaphylaxis after eating eggs, do not administer influenza vaccine, or if a person has anaphylaxis after eating gelatin, do not administer MMR or varicella vaccine. Local reactions are not contraindications. For a table of vaccines supplied in vials or syringes that contain latex, go to www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/latex-table.pdf. For an extensive list of vaccine components, see reference 2.

3. Have you ever had a serious reaction after receiving a vaccination? *[all vaccines]*

History of anaphylactic reaction (see question 2) to a previous dose of vaccine or vaccine component is a contraindication for subsequent doses (1). Under normal circumstances, vaccines are deferred when a precaution is present. However, situations may arise when the benefit outweighs the risk (e.g., during a community pertussis outbreak).

4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder? *[LAIV]*

People with any of these health conditions should not be given the intranasal live attenuated influenza vaccine (LAIV). Instead, they should be vaccinated with the injectable influenza vaccine.

5. Do you have cancer, leukemia, AIDS, or any other immune system problem? *[LAIV, MMR, VAR, ZOS]*

Live virus vaccines (e.g., LAIV, measles-mumps-rubella [MMR], varicella [VAR], zoster [ZOS]) are usually contraindicated in immunocompromised people. However, there are exceptions. For example, MMR vaccine is recommended and varicella vaccine should be considered for adults with CD4+ T-lymphocyte counts of greater than or equal to 200 cells/ μ L. Immunosuppressed people should not receive LAIV. For details, consult the ACIP recommendations (3, 4, 5).

6. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments? *[LAIV, MMR, VAR, ZOS]*

Live virus vaccines (e.g., LAIV, MMR, VAR, ZOS) should be postponed until after chemotherapy or long-term high-dose steroid therapy has ended. For details and length of time to postpone, consult the ACIP statement (1, 5). To find specific vaccination schedules for stem cell transplant (bone marrow transplant) patients, see reference 6. LAIV can be given only to healthy non-pregnant people younger than age 50 years.

7. Have you had a seizure or a brain or other nervous system problem? *[influenza Td/Tdap]*

Tdap is contraindicated in people who have a history of encephalopathy within 7 days following DTP/DTaP given before age 7 years. An unstable progressive neurologic problem is a precaution to the use of Tdap. For people with stable neurologic disorders (including seizures) unrelated to vaccination, or for people with a family history of seizure, vaccinate as usual. A history of Guillain-Barré syndrome (GBS) is a consideration with the following: 1) Td/Tdap: if GBS has occurred within 6 weeks of a tetanus-containing vaccine and decision is made to continue vaccination, give Tdap instead of Td if no history of prior Tdap; 2) Influenza vaccine (TIV/LAIV): if GBS has occurred within 6 weeks of a prior influenza vaccine, vaccinate with TIV if at high risk for severe influenza complications.

8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? *[LAIV, MMR, VAR]*

Certain live virus vaccines (e.g., LAIV, MMR, VAR) may need to be deferred, depending on several variables. Consult the most current ACIP recommendations for current information on intervals between antiviral drugs, immune globulin or blood product administration and live virus vaccines. (1)

9. For women: Are you pregnant or is there a chance you could become pregnant during the next month? *[MMR, LAIV, VAR, ZOS]*

Live virus vaccines (e.g., MMR, VAR, ZOS, LAIV) are contraindicated one month before and during pregnancy because of the theoretical risk of virus transmission to the fetus. Sexually active women in their childbearing years who receive live virus vaccines should be instructed to practice careful contraception for one month following receipt of the vaccine. On theoretical grounds, inactivated poliovirus vaccine should not be given during pregnancy; however, it may be given if risk of disease is imminent and immediate protection is needed (e.g., travel to endemic areas). Use of Td or Tdap is not contraindicated in pregnancy. At the provider's discretion, either vaccine may be administered during the 2nd or 3rd trimester. (1, 3, 4, 5, 7, 8)

10. Have you received any vaccinations in the past 4 weeks?

[LAIV, MMR, VAR, yellow fever] If the person to be vaccinated was given either LAIV or an injectable live virus vaccine (e.g., MMR, VAR, ZOS, yellow fever) in the past 4 weeks, they should wait 28 days before receiving another vaccination of this type. Inactivated vaccines may be given at any spacing interval if they are not administered simultaneously.

References:

1. CDC. General recommendations on immunization. at www.cdc.gov/vaccines/pubs/ace-1a.htm
2. Table of Vaccine Components. www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/latex-table-7.pdf
3. CDC. Measles, mumps, and rubella—vaccine use and strategies for elimination of measles, rubella, and congenital rubella syndrome and control of mumps. *MMWR* 1998; 47 (RR-8).
4. CDC. Prevention of varicella. Recommendations of the Advisory Committee on Immunization Practices. *MMWR* 2007; 56 (RR-1).
5. CDC. Prevention and control of influenza—recommendations of ACIP. at www.cdc.gov/flu/professionals/vaccination.
6. CDC. Excerpt from Guidelines for preventing opportunistic infections among hematopoietic stem cell transplant recipients. *MMWR* 2000; 49 (RR-10); www.cdc.gov/vaccines/pubs/downloads/e_hstc-recs.pdf.
7. CDC. Notice to readers: Revised ACIP recommendation for avoiding pregnancy after receiving a rubella-containing vaccine. *MMWR* 2001; 50 (19).
8. CDC. Prevention of pertussis, tetanus, and diphtheria among pregnant and postpartum women and their infants. Recommendations of the ACIP. *MMWR* 2008; 57 (RR-1).

VACCINE ADMINISTRATION RECORD

Information collected on this form will be used to document authorization for receipt of vaccine(s). Information may be shared through the Wisconsin Immunization Registry (WIR) with other health care providers directly involved with the patient to assure completion of the vaccine schedule. Information collected on this form is voluntary and the Social Security Number will be used by parent or guardian to access the Wisconsin Immunization Registry.

CHART NUMBER

Patient's Name (Last, First, Middle Initial) Include maiden name if married.		Mother's Maiden Name (Last, First, Middle Initial)	
Address		City	State
P. O. Box		County	Zip Code
Email address (if applicable)	Home Telephone Number ()	Work Telephone Number (Include extension number) ()	
Social Security Number	Date of Birth (mm/dd/yyyy)	Patient Birth State/Country	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Race (Check one) <input type="checkbox"/> African American <input type="checkbox"/> White <input type="checkbox"/> Other	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian / Pacific Islander	Ethnicity (Check one) <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino
Eligibility Status (Check all that apply) This section must be completed.		<input type="checkbox"/> Native American <input type="checkbox"/> Medicaid Eligible	<input type="checkbox"/> Badger Care <input type="checkbox"/> No Health Insurance
Name of Physician		Name of School or Day Care (if applicable)	
Name of Insurance Provider		Relationship to Patient	
Name of Parent or Guardian Responsible for Patient (Last, First, Middle Initial)		Relationship to Patient	
Okay to share immunization data with Wisconsin Immunization Registry (WIR)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is reminder or recall contact allowed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Would you like reminder/recall sent to you? <input type="checkbox"/> Yes <input type="checkbox"/> No	
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.			
Wisconsin Medicaid restricts billing recipients for any covered service(s). I understand that if I am a Medicaid/BadgerCare recipient I cannot be charged an administration fee or asked for any type of donation for the administration of any vaccine that is being provided.			
SIGNATURE - Person to receive vaccine or person authorized to sign on the patient's behalf.		Date Signed	

Patient's Name (Last, First, Middle Initial)

FOR OFFICE USE

Vaccine	Route	Site Admin.*	Dose Number	Manufacturer	Lot Number	VIS Form Date ✪ (fill in VIS date)
DTaP/DT	IM	RV LV RD LD	1 2 3 4 5			
DTaP-Hep B-IPV (Pediatrix)	IM	RV LV RD LD	1 2 3	GSK		
DTaP-IPV (Kinrix)	IM	RV LV RD LD	1	GSK		
DTaP-IPV-Hib (Pentacel)	IM	RV LV RD LD	1 2 3 4	Sanofi		
Hep A	IM	RV LV RD LD	1 2			
Hep B	IM	RV LV RD LD	1 2 3 4			
Hep A-Hep B (Twinrix)	IM	RV LV RD LD	1 2 3	GSK		
Hib	IM	RV LV RD LD	1 2 3 4			
Hib-Hep B (Comvax)	IM	RV LV RD LD	1 2 3	Merck		
HPV (Human papillomavirus)	IM	RV LV RD LD	1 2 3	Merck		
Influenza	IN**		1 2			
Meningococcal Conjugate (MCV4)	IM	RV LV RD LD	1 2			
MMR	SQ	RV LV RD LD	1 2	Sanofi		
Pneumococcal Conjugate (PCV7)	IM	RV LV RD LD	1 2 3 4	Merck		
Polio	IM or SQ	RV LV RD LD	1 2 3 4	Wyeth		
Rotavirus	Oral		1 2 3	Sanofi		
Td	IM	RV LV RD LD	1 2 3			
Tdap	IM	RV LV RD LD	1			
Varicella	SQ	RV LV RD LD	1 2	Merck		
Other						

*RV=R Vastus Lateralis, LV=L Vastus Lateralis, RD=R Deltoid, LD=L Deltoid Subcutaneous injections are administered in the muscle "area". **IN = Intranasal
 ✪ Use most current Vaccine Information Statement (VIS) or if appropriate use the Multi Vaccines Information Statement (VIS). For Td & Tdap use the combination Td/Tdap VIS

SIGNATURE AND TITLE - Person Administering Vaccine _____ Date Vaccine Administered _____
 X

Address - Clinic, Public Health Department _____