



Please select month vaccine was administered		Provider's Name	Contact Name	VFC provider number
<input type="checkbox"/> September	<input type="checkbox"/> January	Provider's Address	Telephone Number	Medicaid number
<input type="checkbox"/> October	<input type="checkbox"/> February		()	
<input type="checkbox"/> November	<input type="checkbox"/> March	City	Zip	
<input type="checkbox"/> December	<input type="checkbox"/> April			

Please complete all sections on this form

Patient Name	Date of Birth	Date of Service (month/day)	PATIENT ELIGIBILITY STATUS and VACCINE DOSES ADMINISTERED										
			Preservative Free (QIV) (.25 ml dose prefilled-syringes) VFC Only 6-35 mo.			Preservative Free (QIV) (0.5 ml dose prefilled-syringes) VFC Only 3-18 yrs.			Flu Mist (LAIV) (Single dose) Healthy Children Only VFC Only 2-18 yrs.				
			MEDICAID & MED. HMO'S	NO INSURANCE (Self pay)	NATIVE AMER or ALASKAN	MEDICAID & MED. HMO'S	NO INSURANCE (Self pay)	NATIVE AMER or ALASKAN	MEDICAID & MED. HMO'S	NO INSURANCE (Self pay)	NATIVE AMER or ALASKAN		
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15	/ /	/											
TOTAL <u>DOSES GIVEN FOR EACH CATEGORY</u> : (i.e., add doses given in all eligibility categories for preservative-free syringe 6-35 months)													

Provider's signature: _____ Date: / /

*Sheets to be kept on file for 6 years

