Colorado Expanded Vaccine Administration Record Sheet for Adults

Clinic Name/Address:	Patient Name _____ DOB _____ Address _____ City _____ Zip Code _____ Phone Number _____

Before administering any vaccines, give the patient copies of all pertinent Vaccine Information Statements (VISs) and make sure he/she understands the risks and benefits of the vaccine(s). Update the patient's personal record card or provide a new one whenever you administer vaccine.

Vaccine	Vaccine Administered			Vaccine		Vaccine Information Statements		Vaccine Administrator Signature/Title
	Type of Vaccine[1]	Date mm/dd/yy	Site[2]	Mfr.	Lot #	Date on VIS[3]	Date VIS Provided[3]	
Tetanus, Diphtheria, (Pertussis) (e.g., Td, Tdap) Give IM.								
Hepatitis A (e.g., HepA, HepA-HepB) Give IM.								
Hepatitis B (e.g., HepB, HepA-HepB) Give IM.								
Human Papillomavirus (HPV) Give IM.								
Measles, Mumps, Rubella (MMR) Give SC.								
Varicella (Var) Give SC.								
☐ Check this box if this patient has a physician-certified reliable history of chickenpox. Date box checked ____/____/____. A reliable history of chickenpox is defined as: 1) physician interpretation of patient description of chickenpox; 2) physician diagnosis of chickenpox; or 3) laboratory proof of immunity.								
Pneumococcal, polysaccharide (PPV) Give SC or IM.								
Meningococcal (e.g., MCV4, conjugate; MPSV4, polysaccharide) Give MCV4 IM. Give MPSV4 SC.								
Zoster (Zos) Give SC.								
Influenza (e.g., TIV, inactivated; LAIV, live, attenuated) Give TIV IM. Give LAIV Intranasal.								
Other								
Other								

[1]Record the generic abbreviation for the **type of vaccine** given (e.g., PPV, HepA-HepB), not the trade name. For combination vaccines, fill in a row for each separate antigen in the combination. [2]**Site:** RA = Right Arm; LA = Left Arm; RT = Right Thigh; LT = Left Thigh; IN = Intranasal. [3]Record the **publication date of each VIS as well as the date it is given to the patient.**

Travel/At Risk Vaccine Administration

Vaccine	Vaccine Administered			Vaccine		Vaccine Information Statements		Vaccine Administrator Signature/Title
	Type of Vaccine[1]	Date mm/dd/yy	Site[2]	Mfr.	Lot #	Date on VIS[3]	Date VIS Provided[3]	
Japanese Encephalitis (JE-VAX)								
Malaria (non-vaccine prophylaxis)	Rx or medication provided on ____/____/____. Type _____ Dosage _____ Number _____ ☐ Patient instructions provided							
	Rx or medication provided on ____/____/____. Type _____ Dosage _____ Number _____ ☐ Patient instructions provided							
	Rx or medication provided on ____/____/____. Type _____ Dosage _____ Number _____ ☐ Patient instructions provided							
Polio (IPV)	Childhood Polio series complete? ☐ Yes ☐ No							
Rabies (HDCV, PCEC)								
Typhoid Vi polysaccharide (Ty-ViPS)								
Typhoid, live oral (Ty21a)	Rx or medication provided on ____/____/____. Type _____ Dosage _____ Number _____ ☐ Patient instructions provided							
	Rx or medication provided on ____/____/____. Type _____ Dosage _____ Number _____ ☐ Patient instructions provided							
	Rx or medication provided on ____/____/____. Type _____ Dosage _____ Number _____ ☐ Patient instructions provided							
Yellow Fever (YF-Vax)								

[1]Record the generic abbreviation for the **type of vaccine** given (e.g., PPV, HepA-HepB), not the trade name. For combination vaccines, fill in a row for each separate antigen in the combination. [2]**Site:** RA = Right Arm; LA = Left Arm; RT = Right Thigh; LT = Left Thigh; IN = Intranasal. [3]Record the **publication date of each VIS as well as the date it is given to the patient.**

COMMENTS/TRAVEL CONSULTATION_____

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I have read or have had explained to me the information contained in the Vaccine Information Statement(s) about the diseases and the vaccine(s). I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and request that each of the vaccine(s) indicated by date on this form be given to me.

Patient signature for the initials below:

_____

Vaccination Date	Initials	Vaccination Date	Initials	Vaccination Date	Initials	Vaccination Date	Initials	Vaccination Date	Initials