Name: _____ Age: _____ DOB: _____

PROVIDER INFORMATION

Vaccine Provider:		
Street Address:	State: MO	Zip Code:

Clinic Site: Encompass		
Street Address:	State: MO	Zip Code:

(Circle the apporpriate vaccine, dose, extermity, site, route and enter manufacturer, lot#, and expiration date.)

FOR CLINICAL USE ONLY

VACCINE	DOSE	EXT	SITE	ROUTE	VIS DATE	MANUFACTURER LOT #	EXP. DATE
DTaP DT Td Tdap	.05mL 1 2 3 4 5	RT LT	Deltoid Vastus Lat	IM			
DTaP/IPV (Kinrix)	0.5mL 5th DtaP-4th IPV	RT LT	Deltoid Vastus Lat	IM			
DT/HepB/IPV (Pediarix)	0.5mL 1 2 3	RT LT	Deltoid Vastus Lat	IM			
Hep A	0.5mL 1.0mL 1 2 3	RT LT	Deltoid Vastus Lat	IM			
Hep B	0.5mL 1.0mL 1 2 3	RT LT	Deltoid Vastus Lat	IM			
Hep A/Hep B (Twinrix)	1.0mL 1 2 3	RT LT	Deltoid	IM			
Hib	0.5mL 1 2 3 4	RT LT	Deltoid Vastus Lat	IM			
HPV (Gardasil-9)	0.5mL 1 2 3	RT LT	Deltoid	IM			
Menactra	0.5mL 1 2	RT LT	Deltoid	IM			
Men B/ Brexero	0.5mL 1 2	RT LT	Deltoid	IM			
MMR	0.5mL 1 2	RT LT	Upper Arm Thigh	SC			
Prevnar 13	0.5mL 1 2 3 4	RT LT	Deltoid Vastus Lat	IM			
Prevnar 20	0.5mL 1 2 3 4	RT LT	Deltoid Vastus Lat	IM			
IPV	0.5mL 1 2 3 4 5	RT LT	Upper Arm Thigh	SC IM			
Pneumococcal (Pneumovax)	0.5mL 1 2	RT LT	Upper Arm Deltoid Vastus Lat	SC IM			
Rotavirus	2.0mL 1 2 3		By Mouth	Oral			
Varicella	0.5mL 1 2	RT LT	Upper Arm Thigh	SC			
Shingrix	1.0mL 1 2	RT LT	Deltoid	IM			
Other		RT LT					

_____ _____

Signature and Title of Vaccine Date

I have been offered a copy of the Vaccine Information Statement(s) (VIS) checked below. I have read, had explained to me, and understand the information in the VIS(s). I ask that the vaccine(s) checked be given to me or to the person named above for whom I am authorized to make this request. I cnsent to inclusion of this immunization in the Immunization Registry for myself or on behalf of the person names above. I understand that is the vaccine is drawn, but not administered, I will still be charged for the cost of the vaccine.

DT DTaP Tdap Td Hep A Hep B Twinrix Hib HPV Meningococcal Men B MMR PCV 13
PVC 20 Pneumovax IPV Rotavirus Varicella Shingrix Other_____

_____ _____

Signature of Patient or Parent/Guardian Date