Report Month: M M [ ][ ] Y Y [ ][ ]

VACCINES ADMINISTERED LOG

Federal ID #: ____________ - ____

Contact Person: ____________________

Contact Phone: (____) _____ - _____

Fill in this circle if zero doses given this month: ○

Provider Name: ____________________

Street Address: ____________________

City: ____________________

Patient Initials *(Please Print)*	Birth Date M M / D D / Y Y Y Y	Eligibility/Insurance *(Fill in Only One)*						Service Date M M / D D / Y Y
		American Indian/ Alaskan Native	Medicaid	Not Insured	Underinsured	NC Health Choice	Insured	
FIRST INITIAL / LAST INITIAL		○	○	○	○	○	○	
NCIR CLIENT ID OR MEDICAL RECORD NUMBER								
FIRST INITIAL / LAST INITIAL		○	○	○	○	○	○	
NCIR CLIENT ID OR MEDICAL RECORD NUMBER								
FIRST INITIAL / LAST INITIAL		○	○	○	○	○	○	
NCIR CLIENT ID OR MEDICAL RECORD NUMBER								
FIRST INITIAL / LAST INITIAL		○	○	○	○	○	○	
NCIR CLIENT ID OR MEDICAL RECORD NUMBER								
FIRST INITIAL / LAST INITIAL		○	○	○	○	○	○	
NCIR CLIENT ID OR MEDICAL RECORD NUMBER								
FIRST INITIAL / LAST INITIAL		○	○	○	○	○	○	
NCIR CLIENT ID OR MEDICAL RECORD NUMBER								
FIRST INITIAL / LAST INITIAL		○	○	○	○	○	○	
NCIR CLIENT ID OR MEDICAL RECORD NUMBER								

Vaccine Administered
(Only For State Supplied Vaccine)

	DTaP	DTaP/IPV/Hib	DTaP/IPV	DT (pediatric)	Td (adult)	Hib (all types)	IPV	MMR	Hep B	Var	Flu	PPV23 (Pneumo)	PCV	DTaP/HB/IPV	MenACWY	Tdap	Rotavirus	Hep A	HPV	MMRV	Men B	Hep B/ Hep A	Nirsevimab
	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
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COLUMN TOTALS:																							
	DTaP	DTaP/IPV/Hib	DTaP/IPV	DT (pediatric)	Td (adult)	Hib (all types)	IPV	MMR	Hep B	Var	Flu	PPV23 (Pneumo)	PCV	DTaP/HB/IPV	MenACWY	Tdap	Rotavirus	Hep A	HPV	MMRV	Men B	Hep B/ Hep A	Nirsevimab

Copies of these logs must be received by the Immunization Branch by the 10th of each month. See back for other instructions.

PURPOSE: (1) To fulfill the Vaccines for Children (VFC) requirement for reporting and accountability of vaccine doses administered; (2) to meet state and federal requirements; (3) to fulfill Vaccines for Children (VFC) documentation requirements; and (4) to provide patient specific immunization information to local health departments.

INSTRUCTIONS: **ONLY USE BLUE OR BLACK BALLPOINT PEN. DO NOT USE PENCIL OR FELT-TIP PENS.**

***Report Month:** Fill in month and year on every page. Please do not include more than one MONTH on a VAL form. Additions and corrected copies from different months should be documented on separate VAL forms rather than on the VAL form(s) for the current month being reported.

***Federal ID and two-digit site number** Record the 9-digit federal tax identification number and the two-digit site number for the FACILITY assigned to you by the Immunization Branch as an identifier. The two-digit number is necessary to differentiate between facilities owned by the same group. Record the 11-digit number on **every page.**

***Provider Name:** Record the official name of your **FACILITY** on **every page** of the log. For example, if Dr. Jones is the solo physician in a facility called "Jones Family Practice" record "Jones Family Practice."

***Address:** Record street address and mailing address, if different for your facility on the first page of the logs. **Only required on the first page.**

***Page ____ of ____:** Number every page. Include total number of pages on the first and last page submitted, i.e. "Page 1 of 24" or "Page 24 of 24."

***Contact Person:** Print the name and telephone number of the primary vaccine coordinator or backup coordinator. 1) whose responsibility it is to ensure the logs are received by the NC

***Contact Phone:** Immunization Program (NCIP) by the 10th of each month, and 2) whom you want the Immunization Branch to call with questions. **Only required on the first page.**

***Zero Doses Given:** If no vaccines were given during the month, complete the top of the form. Fill in the circle indicating that zero doses were given in this month and mail form to the Immunization Branch by the 10th of the month.

***Patient Initials:** Legibly print the first and last INITIALS ONLY of the patient in the appropriate areas. DO NOT include the full first and/or last name of the patient.

***Birth Date:** Print the date of birth as "MM DD YYYY." Fill in the full year i.e., "1999, 2000, etc." (ex: 03-25-2000).

***Eligibility Insurance** Fill in the appropriate circle. Only fill in one circle. When screening patients, providers should select and document the VFC eligibility category requiring the least\ out-of-pocket expense to the parent or guardian. If you cannot obtain information as to whether a patient's insurance covers immunizations, fill in "I."

A = American Indian or Alaskan Native
M= Medicaid
N = Not insured (no health insurance)
U = Underinsured (only at LHD, FQHC, RHC & Deputized Providers-include specific underinsured language)
H = NC Health Choice for Children (NC = s CHIP plan)
I = Insured (insurance covers immunizations)

***Service Date:** Print the service date as "MM DD YY."

***Vaccine Type** For each patient, record the vaccine type given to a patient on that date. **Use this column for state supplied vaccine only.** Do not record any historical data or privately purchased vaccine in this column. For example: ♦ If you give a patient a dose of MMR, please fill in the circle under MMR.

***NCIR Client ID or Medical Record Number** Record patient's NCIR client ID or medical record number.

***Column Totals:** Total the number of doses given in each vaccine column. Record column totals at the bottom of every page.

***Preparation:**

1. Complete the log and return two copies to the Immunization Branch. ***Keep*** *an identical copy for your files.*
2. **MAIL or FAX** completed form to: Immunization Branch, 1917 Mail Service Center, Raleigh, NC 27699-1917 or 1-800-544-3058 (FAX). **The logs must be received by the Immunization Branch by the 10th of each following month.** The Immunization Branch will mail a copy to the local health department in your county if requested.

***Disposition:** You must keep a copy of the completed form(s) for three years.

***Mistakes:** If you make a mistake, draw a line through the entire row that includes the incorrect data.