

NORTH CAROLINA IMMUNIZATION REGISTRY

Organization: [Organization Name]

Site: [Site Name]

Generation Date: [Date]

VACCINE ADMINISTRATION RECORD – ADULT

Information collected on this form will be used to document authorization for receipt of vaccine(s).

CHART NUMBER:

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

Gender:	Date of Birth (MM/DD/YYYY):	Patient County of Residence:
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown		

Ethnicity:

Not Hispanic or Latino Hispanic or Latino Prefer Not to Answer

Race:

American Indian or Alaskan Native Asian Native Hawaiian or Other Pacific Islander Black or African American

White Other Prefer Not to Answer

Mother's Maiden Name (Last, First, Middle Initial):

Eligibility as reported by responsible person (Only check one):

Insured Not Insured Underinsured Medicaid American Indian/Alaskan Native

Name of Responsible Person for Patient (Last, First, Middle Initial):	Relationship to Patient (e.g., Self, Mother/Father, Grandparent, etc.):
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Address:	P.O. Box
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City:	County:	State:	Zip:
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Email Address:	Home Telephone Number:	Work Telephone Number:	Extension:
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Would you like a reminder/recall sent to you? Yes No

I am the person receiving the vaccine/I am the parent/I am authorized by the parent, guardian, or person standing in loco parentis of the above-named patient to obtain needed vaccines for the patient.

I have received the "Vaccine Information Statements" (VIS) about the disease(s) and vaccine(s). I have had a chance to review the VIS(s) and to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and request the vaccine(s) indicated below to be given to me or the person named above for whom I am authorized to make this request.

SIGNATURE (Person to receive vaccine or person authorized to sign on the patient's behalf):	Date Signed:
X	

FOR OFFICE USE:

Immunization	Trade Name	Lot	Dose Amount	Body Site				Route	Date of Admin	VIS Pub. Date	Notes
				RV	LV	RD	LD				
COVID-19								IM			
Flu								IM			
Tdap/Td								IM			
HepB								IM			
HPV								IM			
MMR								IM / SC			
Pneumococcal								IM / SC			
Zoster								IM			
Varicella								SC			
Other											

*RV = Right Vastus Lateralis LV = Left Vastus Lateralis RD = Right Deltoid LD = Left Deltoid

*Subcutaneous (SC) injections are administered in the muscle "area".

Ordering Authority (Please Print):

Administered By (Please Print):

SIGNATURE AND TITLE (Person administering vaccine):

X