Arizona VFC Patient Immunization Log

Practice Name:

Address:

PIN:

Area Code & Phone Number:

Area Code & Fax Number:

VFC Contact Name:

Date log begins:

Date log ends:

VFC Eligibility Code*

NAME (optional)	DOB	Age	0	1	2	3	4	5	D T a P	DTaP Hep B Ipv	DTaP IPV Hib	DTaP IPV	Hib	HIBMENCY	Hep A	Hep B	HPV	e-IPV	M M R	M M R V	MCV	PPV 23	PCV 13	Rotovirus	Td	Tdap	Varicella
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***VFC CODES = 0-KidsCare, 1-AHCCCS, 2-Uninsured, 3- American Indian/Alaska Native, 4- Under insured, 5- Private Insurance** **Revised 3/6/14**

******Please do not fax or mail patient logs to VFC. Keep for your records only ******