Arizona VFC Patient Immunization Log

PIN:

Practice/Provider Name:		**Address:**
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**	**Td >7 yr**	**DTaP**	**DTaP HepB IPV**	**Hib**	**Hep B Hib**	**IPV**	**MMR**	**MMRV**	**HEPB**	**VAR**	**HEPA**	**PCV7**	**Tdap**	**HEPB 2 dose**	**MCV4**	**FLU 0.25 mL 6-35 mo**	**FLU 0.5 mL 3-18 yrs**	**FLU Intra nasal**	**PPV 23**
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Vaccine	**Lot#**	**Exp. Date**	**Vaccine**	**Lot#**	**Exp. date**	**Vaccine**	**Lot #**	**Exp. date**	**Vaccine**	**Lot #**	**Exp. date**	**Vaccine**	**Lot #**	**Exp. date**
Td ≥ 7 yrs			Hep B/Hib			Hep PF			Tdap			Flu 0.5mL		
DtaP			IPV			Varicella			Hep B-2			Flu –Live Intranasal		
DTaP/HepB/ IPV			MMR			Hep A**			MCV 4			PPV 23		
Hib			MMRV			PCV 7			Flu PF 0.25mL			OTHER		

***VFC CODES = 0-KidsCare, 1-AHCCCS, 2-Uninsured, 3- American Indian/Alaska Native, 4- Under insured, 5- Private Insurance**

Revised January 13, 2006