CT DPH Vaccine Administration Record

Patient's Name:_____DOB:_____
Parent/Guardian:_____
Address:_____
Insurance:_____Medicaid#:_____

CIRTS

Provider Name/Address:

Vaccine and route (circle type given)	Date Vaccine & VIS given	Site given	Vaccine lot number	Vaccine manufacturer	VIS publication date	Signature/ initials of vaccine administrator	Signature/initials of parent or guardian *(optional)*
Hepatitis B - 1 __ mcg (IM)							
Hepatitis B - 2 __ mcg (IM)							
Hepatitis B –3 __mcg (IM)							
Hepatitis B __mcg (IM)							
DTaP/IPV/Hib- 1 (IM)							
DTaP/IPV/Hib- 2 (IM)							
DTaP/IPV/Hib- 3 (IM)							
DTaP/IPV/Hib- 4 (IM)							
DTaP/IPV- 1 (IM)							
DTaP/Hep B/IPV comb –1 (IM)							
DTaP/Hep B/IPV comb –2 (IM)							
DTaP/Hep B/IPV comb –3 (IM)							
Hib – 1 (IM)							
Hib – 2 (IM)							
Hib – 3 (IM)							
Hib – 4 (IM)							
Polio – 1 (SQ•IM)							
Polio – 2 (SQ•IM)							
Polio – 3 (SQ•IM)							
Polio – 4 (SQ•IM)							
Pneum conj (PCV) - 1 (IM)							
Pneum conj (PCV) – 2 (IM)							
Pneum conj (PCV) – 3 (IM)							
Pneum conj (PCV) – 4 (IM)							
DTaP • DT • Td – 1 (IM)							
DTaP • DT • Td – 2 (IM)							
DTaP • DT • Td – 3 (IM)							
DTaP • DT • Td – 4 (IM)							
DTaP • DT • Td – 5 (IM)							
Rotavirus- 1 oral							
Rotavirus- 2 oral							
Rotavirus- 3 oral							

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Varicella –1 (SQ)							
Varicella –2 (SQ)							
MMR · MMRV – 1 (SQ)							
MMR · MMRV – 2 (SQ)							
Hepatitis A – 1 (IM)							
Hepatitis A – 2 (IM)							
DTaP/Hib –4 (IM)							
Hib/Hep B –1 (IM)							
Hib/Hep B –2 (IM)							
Hib/Hep B –3 (IM)							
HPV- 1 (IM)							
HPV- 2 (IM)							
HPV- 3 (IM)							
Tdap- 1 (IM)							
Meningococcal Conj. (IM)							
Meningococcal Poly. (SC)							
Pneumococcal Poly. (SQ-IM)							
Pneumococcal Poly. (SQ-IM)							
Herpes Zoster (SQ)							
Hepatitis A/B- 1 (IM)							
Hepatitis A/B- 2 (IM)							
Hepatitis A/B- 3 (IM)							
Influenza- 1 (IM) or nasal							
Influenza- 2 (IM) or nasal							
Influenza- 3 (IM) or nasal							
Influenza- 4 (IM) or nasal							