

Name _____

Age _____

DOB _____

PROVIDER INFORMATION

Vaccine Provider: Marshall County Health Department
600 Broadway
Marysville, KS 66508
785-562-3485

Clinic Site:

Street Address:

State:

Zip Code:

(Circle the appropriate vaccine, dose, extremity, site, route, and enter the manufacturer, lot# and expiration date)

Vaccine	Dose	Ext	Site	Route	VIS Dates	Manufacturer & Lot #	Exp
DTaP/HepB/ IPV	1 2 3	RT LT	Deltoid Vastus Lat	IM	9-18-08	GSK	
DTaP/HIB/ IPV	1 2 3 4	RT LT	Deltoid Vastus Lat	IM	9-18-08	SP	
DTaP/IPV	3 4 5 / 3 4	RT LT	Deltoid Vastus Lat	IM	5-17-07 01-01-00	GSK	
DTaP, Td, Tdap	1 2 3 4 5 B	RT LT	Deltoid Vastus Lat	IM	5-17-07 11-18-08 9-18-08	SP,GSK	
Hep A	1 2	RT LT	Deltoid Vastus Lat	IM	3-21-06	GSK,Merck	
Hep B	1 2 3	RT LT	Deltoid Vastus Lat	IM	7-18-07 9-18-08	GSK, Merck	
Hib	1 2 3 4	RT LT	Deltoid Vastus Lat	IM	12-16-98 9-18-08	GSK,,Merck,SP	
HPV	1 2 3	RT LT	Deltoid Vastus Lat	IM	5-3-11	GSK, Merck	
Influenza	1 2	RT LT	Deltoid Vastus Lat	IM	8-10-10	Novartis, SP, GSK	
Influenza (Flu-mist)	1 2	-	Nasal	Intranasal	08-10-10	MedImmune	
IPV	1 2 3 4	RT LT	Upper Arm Thigh	SQ	01-01-00	SP	
Meningococcal (MCV4)	1 2	RT LT	Deltoid	IM	1-28-08	SP	
MMR	1 2	RT LT	Upper Arm Thigh	SQ	3-13-2008	Merck	
PCV13	1 2 3 4	RT LT	Deltoid Vastus Lat	IM	4-16-10 9-18-08	Wyeth/Pfizer	
PPSV23	1 2	RT LT	Deltoid Upper Arm	IM SQ	10-06-09	Merck	
Rotavirus	1 2 3	-	PO	Oral	12-06-10	Merck, GSK	
Varicella	1 2	RT LT	Upper Arm Thigh	SQ	3-13-2008	Merck	
Zoster	1	RT LT	Upper Arm	SQ	10-06-2009	Merck	

*VIS Publication Date must be entered for each VIS distributed to the patient or parent/guardian.

Rev.05/2011

Signature and Title of Vaccine Administrator _____

Date _____

Return Visit Date _____