Provider Name _____

Provider Address _____ **City** _____ **ZIP** _____

Immunization Administration Record Sheet/ Approved Colorado Certificate of Immunization

Colorado Department of Public Health and Environment

Name _____ DOB _____ Parent _____

Address _____ City _____ ZIP _____ Phone _____

VFC Qualified: ☐ Yes ☐ No If Yes, check one: ☐ Medicaid, ☐ American Indian or Alaskan Native, ☐ No Insurance, ☐ Has health insurance that does not pay for vaccines (applies only to FQHCs and rural health centers)

I have read or have had explained to me the information contained in the Vaccine Information Statement(s) about the disease(s) and the vaccine(s). I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated below be given to me or to the person named above for whom I am authorized to make this request.

Vaccine	Parent/Guardian Signature	Immun. Date	Site Given[1]	Manufacturer/ Lot Number	VIS & Date[2]	Date VIS Given[3]	Administered By (Name/Title)
HepB-1							
HepB-2							
HepB-3							
DTaP/DTP/DT-1							
DTaP/DTP/DT-2							
DTaP/DTP/DT-3							
DTaP/DTP/DT-4							
DTaP/DTP/DT-5							
Hib-1							
Hib-2							
Hib-3							
Hib-4							
IPV/OPV-1							
IPV/OPV-2							
IPV/OPV-3							
IPV/OPV-4							
MMR-1							
MMR-2							
Var-1							
Var-2							
Varicella Disease:	yes ☐ Date:_____						

(continues on back)

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the release of the information on this immunization administration record sheet/approved Colorado certificate of immunization (front and back) to or from any of the following: health care provider, clinic, hospital, or public health agency providing care to the person named above; managed care organization or health insurer in which the person named above is enrolled as a member of or insured by; or school/child care in which the person named above is enrolled. I understand the information will be released for the specific purpose of verifying the immunization status of the person named above. The authorization will remain valid through the above-named person's entire school/college history. A photocopy of this authorization shall be as valid as the original.

_____ Signature

_____ Relationship (self, parent, legal guardian)

_____ Date

[1]**Site Given Legend: RA**=Right Arm, **LA**=Left Arm, **RT**=Right Thigh, **LT**=Left Thigh, **O**=Oral

[2]**VIS & Date:** Type & revision date of Vaccine Information Statement given to parent *e.g.,* MMR 12/16/98

[3]**Date VIS Given:** Date of which patient, parent or guardian was given Vaccine Information Sheet

April 2001

Name _____ DOB _____

I have read or have had explained to me the information contained in the Vaccine Information Statement(s) about the disease(s) and the vaccine(s). I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated below be given to me or to the person named above for whom I am authorized to make this request.

Vaccine	Parent/Guardian Signature	Immun. Date	Site Given[1]	Manufacturer/ Lot Number	VIS & Date[2]	Date VIS Given[3]	Administered By (Name/Title)
Hep A-1							
Hep A-2							
Td-1							
Td-2							
Td-3							
Pneumococcal Conjugate-1							
Pneumococcal Conjugate-2							
Pneumococcal Conjugate-3							
Pneumococcal Conjugate-4							
Pneumococcal Polysaccharide							
Influenza							
Meningococcal							
Meningococcal							

LEAD SCREENING (A Medicaid Requirement): ☐ 12 months—Level_____ ☐ 24 months—Level_____

[1]**Site Given Legend: RA**=Right Arm, **LA**=Left Arm, **RT**=Right Thigh, **LT**=Left Thigh, **O**=Oral
[2]**VIS & Date:** Type & revision date of Vaccine Information Statement given to parent *e.g.,* MMR 12/16/98
[3]**Date VIS Given:** Date of which patient, parent or guardian was given Vaccine Information Sheet

TO THE BEST OF MY KNOWLEDGE, THE PERSON NAMED ABOVE HAS RECEIVED THE IMMUNIZATIONS REQUIRED FOR SCHOOL/CHILD CARE ENTRY

DO NOT SIGN UNLESS MINIMUM IMMUNIZATION REQUIREMENTS FOR AGE OR GRADE ARE MET

Signed _____ Title _____ Date _____
(Physician, nurse or school health authority)

STATEMENT OF EXEMPTION TO IMMUNIZATION LAW

IN THE EVENT OF AN OUTBREAK, EXEMPTED PERSONS WILL BE SUBJECT TO EXCLUSION FROM SCHOOL AND QUARANTINE.

MEDICAL EXEMPTION: The physical condition of the above named person is such that immunization would endanger life or health, or is medically contraindicated due to other medical conditions.

Medical exemption *to the following vaccine(s).*

Signed _____ Date _____ Optional to list:_____
(Physician)

RELIGIOUS EXEMPTION: Parent or guardian of the above named person or the person himself/herself is an adherent to a religious belief opposed to immunizations.

Religious exemption *to the following vaccine(s).*

Signed _____ Date _____ Optional to list:_____
(Parent, guardian, emancipated student/consenting minor)

PERSONAL EXEMPTION: Parent or guardian of the above named person or the person himself/herself is an adherent to a personal belief opposed to immunizations.

Personal exemption *to the following vaccine(s).*

Signed _____ Date _____ Optional to list:_____
(Parent, guardian, emancipated student/consenting minor)