NEW YORK STATE IMMUNIZATION PROGRAM-VACCINES FOR CHILDREN AND CHILD HEALTH PLUS B PROGRAMS
VACCINE ADMINISTRATION LOG SHEET
Sample form for use in your practice only *DO NOT SUBMIT TO NYS*

Call the NYS Immunization Program at (518) 473-4437 if you have any questions regarding this form

Provider Name: _____ Phone Number: _____ PIN : _____

Address: _____ Month/Year (MM/YY): _____

Patient Name or Initials	Date of Birth (mm/dd/yy)	Age	Eligibility Categories: VFC:				CHPB:	DT(Pediatric)	DTaP	DTaP-HepB-IPV	DTaP-Hib	Hep A	Hep B	Hep B -Hib	Hep B 2 dose (11-15 yrs only)	Hib	HPV	Influenza TIV	Influenza LAIV (nasal spray)	IPV (Polio)	MCV4	MMR	MMRV	PCV7	Rotavirus	Td (>7yrs)	Tdap	Varicella
			Medicaid	Uninsured	American Indian/Alaskan Native	Underinsured	Child Health Plus B																					

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